Vol. 15 No. 1 2nd Class Mail Reg No. 2776 TORONTO, January 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

1986 CALENDAR
The centre section

Underground laboratories were the catalyst

Futureshock drugs will defy current concepts

By Anne MacLennan

OTTAWA — The spectre of "microchip" drugs that could revolutionize illicit drug production and overwhelm enforcement efforts is alarming experts.

The drugs would be enormously powerful, even in microscopic quantities; a small handful would supply a metropolitan city for several years.

And the technology to produce them — cheaply — now exists. It grew out of illicit laboratories in the United States and the manipulation of chemicals to create new, and therefore legally uncontrolled, synthetic drugs with effects similar to those of heroin.

But, "micros" would represent a spectacular advance.

Says Jacques G. LeCavalier, director of Canada's Bureau of Dangerous Drugs here: "It's likely the intent has been more to produce a substance which isn't considered illegal than to produce one that is very potent."

However, some synthetic opiates already produced are 1,000 times more potent than heroin. "And, theoretically, there are thousands and thousands of compounds possible," he says.

"With relatively small and inexpensive amounts of chemicals, you can produce substances that you can cut into microgram quantities, and you don't have the hassle of going through several different countries and customs checks. Your market is right there, on the spot.

"As well, once you manufacture the substance, you can fold down your lab, dispose of the evidence, and market the product. At the same time, you can produce sufficient quantities to provide a city for several years."

Narcotics experts with the Royal Canadian Mounted Police (RCMP) are also concerned about "micros."

RCMP Chief Superintendent Rodney T. Stamler, director of the Drug Enforcement Directorate here, told **The Journal**: "We are, and we have to be, concerned, not only from an enforcement, but also from a health perspective.

"When you're looking at what you can do now with chemicals, or at what you can start to consider doing, it's clear the availability of drugs in any country wouldn't have to be determined by a supply line from South East Asia.

Stamler: fraction of the cost

"We could get to a point where you can take a small quantity, process it, and feed the addict population of North America.

"They're developing the techniques now to manufacture these extremely potent drugs . . . at a fraction of the cost it takes to put a supply line in place from the opium field to the distribution system in any country. Production of drugs as we now see it could change completely."

Blackwell: awesome potential

Chief Supt Stamler says the possibilities underline yet again "the fact that enforcement alone cannot succeed in reducing drug abuse. The answer has to lie in changing the attitudes of people — especially the young — the kind of thing we may be seeing in some of the student surveys (**The Journal**, December, 1985).

"People have to start looking at drug use differently. The focus has to be on reducing demand, as well as on reducing supplies."

Sociologist Judith Blackwell, a drug policy analyst at Ontario's Addiction Research Foundation (ARF), has been watching development of the illicit synthetics for some time and with growing trepidation. She agrees microchip drugs are almost inevitable.

LeCavalier: supply a city

In a course she gives on drug policy at the ARF's School for Addiction Studies in Toronto, she raises the issue with classes and speculates on the awesome potential in such new "drug inventions." Students "quickly grasp the appalling policy implications," she says.

From her point of view: "Even if we were to succeed in closing all of

(See Microchips, p2)

Ex-addict athletes rarely regain 'edge'

By Harvey McConnell

NEW YORK — Top-class professional athletes recovering from cocaine addiction seldom regain their competitive edge without serious risk of relapse.

This is the experience of Forest Tennant, MD, DPH, substance abuse consultant to the Los Angeles Dodgers, researcher, and director of a number of community-based medical and substance abuse clinics in the Los Angeles area.

"In fact, the situation is so common now that I have written a monograph about what I call the post-drug impairment syndrome," Dr Tennant told **The Journal**.

"My clinical observation is that no more than 10% to 20% of such athletes can go back to their previous level of competence and perform at that level for more than one season without relapsing. Some do, of course, but for every one I see who does, there are ten I see who are not playing anywhere near where they were before."

The athletes lose not only their competitive edge, but also no longer seem able to stand the physical pain of competition. This ranges from a pitcher with a sore arm to a football player being tackled hard.

"I can't document this, of course — I don't know how you measure this kind of pain — but, it is certainly my clinical observation, and it is very sad," he added.

Dr Tennant told a clinical conference on cocaine here that while he does not agree with *en masse* urine testing for drugs in many situations, he does favor it for young athletes.

"You have a medical reason to test them, because if they are under the influence of drugs they can get hurt."

He said a message needs to go out to young people that would put a stop to the belief by a lot of them that "they can take these drugs, get off, and not leave damage behind. They can't, not if they play sports for money."

The cocaine epidemic in professional sports appears to be on the wane, Dr Tennant said. In major league baseball, for example, not a single new case of cocaine dependence has come to the attention of authorities in the past two years.

Nor have many players had to be fired: many of those addicted to cocaine have suffered from the post-drug impairment syndrome, their performance has not been what it once was, and they have faded from view.

He has found few players begin their drug use in professional sports: they start in high school or college, there are almost no cocaine-only abusers, the drug is combined with marijuana and alcohol by a large majority, and all of the abusers are dependent on nicotine.

Dr Tennant believes there is too much pressure today on "getting industry into policing drug use,

Tennant: leaving damage behind

and that is not industry's job." At the same time, however, people with specific responsibilities, such as pilots, train enginecrs, and bus and truck drivers, had "better be willing to show people they are not on drugs. This is not any invasion of their privacy."

Cigarette smoke now implicated in sudden infant death syndrome

WASHINGTON — Seventy percent of mothers of babies who died from sudden infant death syndrome (SIDS) were smokers during pregnancy, preliminary data from a United States study show.

Charlotte Catz, MD, of the US National Institute of Child Health and Human Development here, said the six-centre study which began in 1979 is the largest epidemiological study of SIDS ever undertaken. The SIDS victims were compared with 1,600 control infants.

Dr Catz told a House of Representatives committee that final results of the study will be available early in 1986. What has emerged so far, in addition to the link with maternal smoking, is that black infants were nearly three times as likely to be victims of SIDS, 32% of the SIDS infants were born to teenage mothers, and nearly 60% were male.

National SIDS Foundation President Marie Valdes Dapena, MD, professor of pathology and pediatrics, University of Miami, said in written testimony to the committee that autopsies of SIDS infants found many had scarring around the brain stem. This could be the result of oxygen deficiency or some other malfunction.

"All we know is that the scar is there and whether it is cause or effect, we do not know," she added. The study has dispelled the accepted feeling that infants who die from SIDS are perfectly normal. "Now, it appears that is not so."

Mila bows out

Mulroney: emotionally involved

TORONTO — Mila Mulroney will not lead a crusade against drug abuse, as she had debated doing (The Journal, May, 1985), her assistant, Bonnie Brownlee, has told The Journal.

Ms Brownlee said the prime minister's wife has decided to continue fund raising for cystic fibrosis research.

"She has made a commitment to cystic fibrosis and has become emotionally involved with these children. Some of them are good friends of hers, and she knows they are dying. She wants to do what she can," Ms Brownlee said.

Mrs Mulroney considers drug abuse an important issue. But, she finds her work for cystic fibrosis and multi-culturalism, in addition to travelling extensively with the prime minister, fully occupies her time, Ms Brownlee said.

INSIDE

NEWS

Briefly ...

Breathe deeply now

LONDON — Doctors here believe breathing and relaxation classes for patients have cut down prescriptions for tranquillizers. The pilot study has helped patients from six general practices, says *Doctor*. Co-organizer Jane Whitehead, a health education officer, believes relaxation can also help patients deal with smoking, alcohol abuse, insomnia, and hypertension.

Beer measures up

LONDON — While British beer drinkers like lots of froth ("good head") on their beer, they're nevertheless grumbling about being shortchanged. Bureaucrats here say drinkers are being short-measured to the value of more than £320 million (Cdn $637 million) a year by accepting pints with "heads" which are far too deep. The only solution, they insist, is for the government to enforce a kind of "bottom line" for drinkers, pint glasses with a special mark up to which the liquid must flow and above which the head must sit, says *The London Sunday Times*.

Price wars

TORONTO — Falling sales are driving cigarette manufacturers in Canada to drop prices on selected brands. Industry spokesmen are blaming rising taxes for the discounts, which they say are only temporary, reports *The Toronto Star*.

Coded to confuse

SYDNEY — Children are unlikely to notice or understand printed warnings against sniffing dangerous solvents and aerosols. Even adults can't comprehend some of the cautions, says psychology professor Phillip Lcy of Sydney University here. An industry representative, however, told *Connexions* the labels are deliberately worded in difficult language so children will not be tempted to try sniffing.

Easy on the eyes

CHICAGO — People contemplating a facelift should quit smoking first, says a report from the University of Toronto to the American College of Surgeons meeting here. Studies by Christopher Forrest on pigs and rats show animals exposed to tobacco smoke had more failure of skin flap tissue — common in cosmetic surgery — than animals who weren't exposed to smoke, says *The Toronto Star*.

Glamor rubs off

WASHINGTON — As the lights go down in local cinemas, movie buffs may soon see this printed warning on the screen: "Notice — this film contains paid advertising for Johnny Walker scotch, Marlboro cigarettes, Budweiser beer, and Coca-cola." The Center for Science in the Public Interest (CSPI) here is pushing for the warning. In a press release, CSPI president Michael Jacobsen says: "The glamor of the stars rubs off on the products. This is particularly unfortunate when harmful and addictive products like alcoholic beverages and cigarettes are featured in films seen by millions of youth."

Ontario bolsters treatment funding

$2.8 million for community-based residential care

By Joan Hollobon

TORONTO — The Ontario government is committing an additional $4.3 million to community-based alcohol and other drug addiction treatment programs, bringing the total to $14.2 million from $9.9 million.

Ontario Health Minister Murray Elston said the growing incidence of alcohol and other drug abuse requires "its own particular response from our health care system."

Ontario has an estimated 200,000 alcoholics — 3% of the population — with another 3% drinking enough to put them at risk of alcoholism, the minister told the legislature last month.

He said $2.8 million is being allocated to pay full costs of residential treatment in those community-based programs that offer it, in order to remove "a discrepancy in the kinds of insured services available to people."

Until now, community services have been funded only for programs and have been obliged to charge clients for room and board, whereas patients receiving hospital treatment for alcohol-related problems have been fully covered by the Ontario Health Insurance Plan.

Four new residential programs at Timmins, North Bay, Thamesville, and Toronto were added to the four existing programs at Ottawa, Toronto, Sudbury, and Hearst. Together, these are expected to treat some 1,800 people a year.

The other $1.5 million enabled 13 new community programs to open January 1, in addition to the four residential programs, increasing the total of community services to 83 from 66.

In Toronto, the Jean Tweed Treatment Centre has added a 15-bed residential component to the day care program, which treated 115 women during its first year of operation, with a success rate of 75%. Seventy-five women are enrolled in an aftercare program.

The Renascent Treatment Centre will provide Toronto's second residential treatment unit.

Mr Elston said women's health issues are a priority of the health ministry. Between 25% and 35% of all alcoholics in Ontario are women. In Metro Toronto, there are an estimated 38,000 women alcoholics, yet the ratio of male to female detoxification facilities is 16 to one.

Services for women, for the elderly, for francophones, for families, and for the Portuguese community in Toronto are among the 21 programs receiving new or increased funding from the additional $4.3 million allocated to addiction services.

The minister told the legislature the new funding will help achieve a more effective balance between institutional and community-based addiction programs.

This objective, which is further elaborated in a recently-issued summary of the health ministry's policy on addictions services, was welcomed by Joan Marshman, PhD, president of Ontario's Addiction Research Foundation.

"This is consistent with emerging research evidence," Dr Marshman told **The Journal**.

The major objectives of the new funding are to provide a clear direction for the development of effective and accessible addictions services and to establish a framework within which planners can make better use of existing resources to develop appropriate programs, including services for groups with special needs.

Elston: discrepancy

Processing labs being set up in Canada

Cocaine use, trafficking still on rise: RCMP

By Anne MacLennan

OTTAWA — Cocaine is now by far the most widely-accepted and used illicit drug in Canada, after marijuana, says Rodney T. Stamler, director, Canada's Drug Enforcement Directorate.

And there are strong indications both use and availability will continue to rise, Chief Superintendent Stamler of the Royal Canadian Mounted Police (RCMP) told **The Journal**.

"There is greater use now by the public in general, and use is still spreading to lower age groups. There's been a rather sharp increase in the past year among people in their early 20s — people just entering the workforce and with money to buy."

At the same time, the criminal "families" who operate the world cocaine trade from South America are, for the first time, establishing distribution centres of their own here, he said.

Until now, distribution in Canada was largely the work of Canadians, or residents here, who went to Miami or South America, bought the drugs, and returned to distribute.

"Now, in Montreal, Toronto, and Vancouver, we see South Americans establishing their own centres," he said.

As well, laboratories are being set up in Canada to process cocaine hydrochloride, the popular white powder, from *pasta* (or paste), a mid-stage product in the transformation of leaf to cocaine (**The Journal**, October, 1985).

The establishment of pasta-labs is partly the result of more stringent enforcement in source countries and partly because the required chemicals are cheaply and easily available in Canada. As well, the peculiar odors formed in the processing are still relatively unfamiliar in this country and thus less likely to be detected.

The conversion ratio for pasta to powder is 2.5:1, and the profit potential immense.

Two kilograms of pasta sell at source for between $1,200 and $2,000. Converted to 1 kg of cocaine, it sells to wholesalers for between $6,500 and $32,000, depending on the wholesaler's connections. The better the connections, the better the price.

After cutting the drug to 50% purity, the wholesaler charges between $60,000 and $90,000 per kg. Further cut and repackaged, the cocaine fetches between $100 and $300 per gram on the street. Again, prices vary with sales-site and tend to be lower in large urban centres.

Chief Supt Stamler was speaking prior to the expected release this month of the fourth annual RCMP National Drug Intelligence Estimate (**The Journal**, January, 1985) — this one for 1984-85. [Full coverage next month.]

The enforcement directorate was established last year by the RCMP. Then-Superintendent Stamler, officer in charge, Drug Enforcement Branch, was named chief superintendent and director.

Establishment of the directorate reflects both increased commitment to drug issues by the RCMP and increased authority for RCMP narcotics experts.

Microchips: the health prospects are alarming

(from page 1)

our borders to imported drugs, which is impossible, and stop domestic cultivation and prevent diversion of drugs from medical sources, we could not control drug availability.

"We must assume that underground chemists are only going to get better and more sophisticated, as scientific knowledge advances.

"One can only imagine the problem continuing to get worse."

Mr LeCavalier says several hundreds of highly potent compounds have been synthesized by pharmaceutical companies in Europe in the process of screening drugs for potential medical usefulness.

"The concern is that a smart chemist can hook into this. And I think that's what's happening.

"It's obvious that whoever developed alpha-methyl fentanyl (a modification of a controlled synthetic opiate, **The Journal**, April, 1984) was an extremely knowledgeable chemist. Apparently, the amounts circulating on the street were cut to such a point that somebody knew the exact dosage required." (This compound was called China White, also a street label for ultra-pure heroin.)

From a health perspective alone, prospects are alarming. Producers won't know what they're producing, users won't know what they're using, and medical professionals won't know what they're looking for or trying to treat.

Says Mr LeCavalier: "We're, of course, extremely concerned. Every time you create a new compound, you create new health hazards that are synergistic with what's already there. Users are not familiar with the use of the drugs, with the various permutations and combinations. They don't know the exact dose, and they can overdose more readily."

New molecular structures can also produce some grim surprises. An attempt to produce a drug similar to Demerol (pethidine or meperidine) in an illicit California laboratory, produced a drug that caused irreversible Parkinson's Disease in users there.

As far as Canadian officials know, there is no microchip drug development in Canada, "though that doesn't say it doesn't exist here," says Mr LeCavalier.

And, there is consensus among the experts: although Canada and much of the developed world can often see its future in California, at least with respect to drugs, there is usually also a time lag.

Furthermore, says Ms Blackwell: "I think probably the most encouraging thing is that Canadians seem to have been less adventuresome than Americans in this field. We haven't heard yet of a brilliant, underground Canadian chemist."

— coming up in —

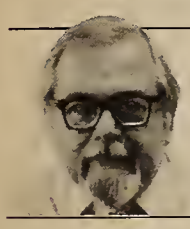
THE JOURNAL

- *Responsible beverage service issues*
- *RCMP Drug Intelligence Estimate 1984/85*

NEWS

Educational campaigns desperately needed

AIDS forcing IV drug users to make decisions



By Harvey McConnell

WASHINGTON — Almost half of the intravenous (IV) drug users questioned in a major New York study have not altered their patterns of sexual behavior even though they know this increases the risks of their contracting AIDS (acquired immune deficiency syndrome).

Paradoxically, 84% of 261 IV drug users studied by Peter Selwyn, MD, and colleagues at the department of epidemiology and social medicine, Montefiore Medical Center, Bronx, New York, said they would stop sharing needles if they had access to a ready supply of sterile needles.

The researchers found that almost all of 146 users in long-term methadone maintenance programs at three clinics and 115 recent admissions to a major detention facility knew about AIDS and how it can be transmitted. But, 48% of them said their sexual activity had not changed.

"In a high-risk population that reports a significant number of sexual encounters with other IV drug users — but perhaps an even larger number of sexual contacts with non-drug users — the implications for heterosexual and vertical transmission (of AIDS) are alarming," Dr Selwyn told the annual conference here of the American Public Health Association.

In addition, and of equal concern, he said, the research team found those who share needles, compared with those who do not, are significantly less likely to mention any reduction of sexual activity even though they are at highest risk of both transmitting and contracting the AIDS virus (HTLV III).

"Effective education among high-risk drug abusers might prove to be as important in the area of sexual-risk reduction as in that of drug and needle use," Dr Selwyn observed.

Study participants were questioned about their knowledge of AIDS, current needle use, sexual practices, and efforts they are making to reduce their risks. The aim in having two groups to study was to compare one group of former drug users already in a treatment program with another group more closely approximating street users.

Overall, subjects in the study tended to be in their early 30s, non-white, with less than a high school education, and unemployed. There were slightly more men (53%) in the study.

Dr Selwyn said that more than 26% of the 4,827 AIDS cases reported in New York city by mid-October 1985 involved heterosexual IV drug users. This percentage would rise to 33% if reported cases occurring in homosexual or bisexual IV drug users were added.

The data suggest IV drug users "occupy a pivotal position in the developing AIDS epidemic and that efforts to control the spread of the disease must focus at least in part on this key risk group," Dr Selwyn said.

Dr Selwyn said the researchers found 77% of the study subjects worried about getting AIDS, and 36% knew at least one person who had contracted AIDS. Some 97% knew AIDS could be contracted from needle sharing; 99% knew they could get hepatitis from needle sharing.

As for sexual practices, 50% of those attending the methadone maintenance clinics and 46% of those in the detention centre said they had not changed their sexual behavior because of any concern about AIDS.

Dr Selwyn said overall findings support the view that IV drug users have responded to the threat of AIDS through a variety of risk-reduction methods — some more effective than others.

Dr Selwyn: "We did not ask subjects directly about a perceived increased demand on the street for sterile needles, although our findings would support observations that such market pressures have, in fact, depleted the available supply of clean needles relative to demand, with emergence of the phenomenon of street needle sellers repackaging used needles and selling them as new."

In addition, the finding that the majority of needle sharers do so more out of expediency and desperation than ignorance is perhaps relevant to the current debate on the merits of providing sterile needles to IV drug users to reduce viral transmission.

Maplines

Dr Selwyn said two recent studies among homosexuals living in San Francisco found the majority had reduced their risk of infection. But, there was a sub-group who continued to engage in high-risk sexual activities despite knowing this increases the risk of AIDS.

There was a similar sub-group among IV drug users: 16% continued to share needles and made no apparent effort to change, even though they knew of the risk of AIDS.

Dr Selwyn said while researchers found they could educate IV drug users about risks and AIDS, education is not enough. Their findings of relatively decreased IV drug use and needle sharing among the methadone maintenance patients bolsters claims for drug treatment as a partial deterrent to ongoing, unbridled, needle use.

Dr Selwyn concluded that "a truly comprehensive approach to the crisis of AIDS among IV drug users will need to include not only desperately-needed educational campaigns, not only additional drug treatment facilities, but also, perhaps in the short-term, attention to the need for more readily available sterile needles and syringes."

INSIDE OUT

A flower in the weeds

It's a rainy day in the late fall and the whistling wind outside brings with it whispers of the winter to come.

Two people are sitting at a table in the near-darkness of a downtown bar. They are happy. They have not talked for several months, and they ease into each other's past with the spontaneous smoothness of friends who have been together at the top, and have gone to the bottom, too, and so there is the unmistakable thread of love tying them tightly now.

He has reminded her of some of the strange things they have shared, those funny, absurd times, because he has wanted so badly to hear her laughter again. And she has spoken of her recent journeys to different places in the world and the changes those places have made in her since the last time they were together.

They've eaten dessert, and they notice they are alone inside, busboys gone, the chirpy waitress disappeared, the bartender, too. And so she looks, suddenly, very gently, into his eyes.

SHE: It's really been a year now for you? Where's it gone? You look great, you know. You look at peace. How has it been going with you, anyway? Really going.

HE: It's so bloody hard to talk about it coherently. I'm afraid to exaggerate any of it, but I'm afraid to diminish it, too. You know what I mean? All I know is that I'd been sober five weeks and it was last New Year's Day — and damn, it was so cold! — and I was walking uptown by myself and I was crying. I was sure there was no place lower to go. I felt doomed. I felt that any good I'd ever done had been erased forever, that any talent I'd ever had had been worthless, and that all the things I thought I knew were just puffs of smoke. Even drinking couldn't cure what I was feeling.

With all that going on inside, and with nobody to talk to about it — because I wouldn't have known what to tell them anyway, and I was in a land without a map — I didn't know, but there was something new growing in me.

SHE: When did you first notice it?

HE: I guess it took hold in the days after the New Year, just before I went to the clinic for a month. What astounds me now is how I ever got through that intervening time — it was only a week but it was endless, really endless — and by the time I got in with the other people, I dumbly realized something had taken hold.

The only way I can describe it is that I felt I had a new body part ticking away inside me. It didn't seem to have anything to do with me, with my efforts. It just kept doing its work and indicating to me I just better get out of its way and let it bloom. Even in the bad days ahead, after that first bomb of getting really sick had gone off and left me in fragments, without a centre, nowhere, feeling amazingly shy and awkward with people, this . . . thing just kept up its special beat. Even when I was told at the clinic just how close I'd come to facing death, it continued, like a metronome.

My own prison term had ended . . . I began to feel whole again

And then, the good times began.

SHE: The good times?

HE: Oh, yeah, the "good" times. Now, let me try to get this straight for you. You've heard all the clichés about alcoholics stopping drinking and how they feel, if they're lucky enough to stay dry, like Rip Van Winkle coming back from the long sleep? How they believe they've been "reborn" and given another chance to try to do it right, and how euphoric they suddenly, inexplicably, feel?

SHE: I've heard them. What about it?

HE: Well, I hate to be banal. But, they're all true. And even when the dark days come now and I am afraid to leave my house for various reasons and, in the night, the ghosts show up all of a sudden, there's still this thing blooming, this rare flower growing in the weeds. And it's not easy to talk about, because I'll be damned if I speak too much of it. In fact, I've had to restrain myself sometimes from blurting out what I now know. Call it etiquette, an instinctive need to keep quiet about it all. I do not want ever to be a "professional" alcoholic, you know?

But I'll tell you, just this once, and we don't really have to talk about it again if you don't want to. Because I know there's a danger, a need to keep it in perspective, all of it, a need in the end, for the great silence.

SHE: What do you mean? You sound like you're trying to shrug off what's obviously one of the most significant things that has ever happened in your life.

HE: I told you it was hard to talk about. I remember a little while ago I checked in at the medical office where I work. I go there about once a month to speak to a nurse about my "progress." Recently, she asked me if I wanted to write a little something for our internal newsletter about how well, apparently, I had been doing. It took me half an hour to tell her I couldn't just write three or four paragraphs about what had happened and why people with my illness should find out about the program at work, and all that. I tried to tell her that it's a thing that leaves you either completely tongue-tied, or your eloquence spills out forever — if you're in a fine mood. And after all, I told her, I've only been alcoholic for a year now, so what the hell do I know anyway, you know?

SHE: *(laughing nicely now)*: Tell me about your high point in all this. Was there a day that's singled out?

HE: Yeah, it's strange. One night, a couple of weeks before my first year sober was over, I was watching this movie, *The Last Detail*. It's about two hard, army lifers taking this poor, dumb, young soldier who's goofed up badly in his short military career away to jail for about eight years. The kid's an innocent hick, he's never experienced anything, not love, not much joy, and now all his hopes are shattered as he faces those years in prison. And these two hard guys on the way to put him behind bars are trying, in their hard-bitten way, to give him a hint of what he'll be missing. They're trying to give him some moments to remember before the iron doors slam in his face.

I don't know why, but I identified with that kid, and how alcohol had shut down so many of my own possibilities. But, that night I felt my own prison term had ended. It was like an early Christmas for me — a real Christmas — and the tears flowed all night and right into the morning, and I began to feel whole again for the first time since I was a teenager.

And suddenly that first year's anniversary loomed, and I knew in my guts and my heart and not in my head that somehow I'd been privy to a small miracle in my life. . . . Sorry . . . didn't mean to get carried away.

SHE: It's all right. It's fine, fine.

HE: And you know? I had fantasies, almost like Scrooge waking up Christmas Day and finding he could save his soul, that the day I woke up and it'd been a whole year without a drink would be the greatest of my life. And it was, oh, yes, it was. But, a very sobering thought hit me as the time for sleep came.

SHE: What was it?

HE: Well, by the end of the day, I knew some of the giddiness had to end. I can't hang on any longer, or as dearly, to the metronome inside me, and now I have to do some of the mundane, but absolutely necessary things I've kind of been avoiding during this amazing year. Now is the time to try to do it, some of it, without a net — at least with only half the net there.

SHE: Like a sequel to a movie, eh?

HE: Yes, I'll let you know how it goes.

This column, exploring addictions from the "inside out," is by a freelance, Canadian writer.

NEWS

RESEARCH UPDATE

Thiamin a boon for therapy?

Animal studies in South Africa suggest adding thiamin to sorghum beer — a product responsible for much of the alcoholism in Southern Africa — could prevent problems caused by the deficiency of this vitamin in heavy drinkers. Using isolated loops of the rat duodenum and adjacent jejunum, three researchers at the South African Institute for Medical Research and the University of the Witwatersrand, Johannesburg, tested the rate of absorption of radio-labelled thiamin added to sorghum beer. They found when 0.3 millilitres of beer containing 2.5 milligrams of thiamin was introduced into the intestinal loop, 10% to 15% — a significant proportion — was absorbed in five minutes, and was not affected by the presence of alcohol or live yeast cells. The researchers say the results indicate "fortification of sorghum beer with thiamin is a feasible measure to prevent the development of deficiency of the vitamin in habitual beer drinkers."

American Journal of Clinical Nutrition, Oct, 1985, v.42:666-670.

Breast cancer/coffee link restudied

An investigation of the possible relationship between coffee consumption and breast cancer in several thousand women has shown no evidence that coffee increases the risk for this type of cancer. The study was undertaken to follow up a recent report that fibrocystic breast disease, a risk factor for breast cancer, regresses after abstention from coffee and other foods containing methylxanthines. In the case-control study, interviews were conducted at several United States teaching and community hospitals between 1975 and 1982 with 2,651 women with newly diagnosed breast cancer. Their responses were compared with those of 1,501 controls with non-malignant conditions and 385 controls with cancers at other sites. The relative risk estimates for levels of coffee drinking from one to seven or more cups daily, relative to none, were approximately 1.0 and after allowance for confounding variables, the relative risk estimate for drinking at least five cups a day was 1.2 using non-cancer controls and 1.1 using cancer controls — in other words, no significant additional risk. Coffee consumption was also not associated with an increased risk of breast cancer among women with a history of fibrocystic breast disease. Consumption of decaffeinated coffee or tea was also unrelated to breast cancer. The researchers from the Boston University and University of Pennsylvania schools of medicine and the Memorial Sloan-Kettering Cancer Center, New York, conclude that data from the study do not support any hypothesis of a relationship between recent coffee consumption and breast cancer.

American Journal of Epidemiology, Sept, 1985, v. 122:391-398.

Stomach upsets follow alcohol/other drug use

Alcohol can worsen the effect other drugs have on the stomach lining. Using 60 healthy volunteers, researchers at Baylor College of Medicine, Houston, Texas, and The Upjohn Company, Kalamazoo, Mich, evaluated the effect of acetylsalicylic acid (ASA), the anti-inflammatory drug ibuprofen (Amersol), and placebo on the stomach lining with or without alcohol. Subjects received four doses of either three 325 milligram ASA tablets, one 600 mg ibuprofen tablet, or placebo tablets in a 24-hour period. With each dose, subjects were given drinks with three ounces of 100-proof vodka and six ounces of orange juice, or a similar alcohol-free drink. Eight hours after the last dose, gastric and duodenal examination was carried out with an endoscope. Comparing all subjects taking other drugs with alcohol with those not taking alcohol, the researchers found a significant increase in gastric — but not duodenal — mucosal damage. But, there were considerable individual differences in the amount of damage. The researchers conclude the findings are compatible with alcohol "being a mild potentiating agent for increased damage from agents that are noxious to the stomach."

American Journal of Gastroenterology, Oct, 1985, v. 80:767-769.

Gamblers, heroin addicts scrutinized

Pathological gamblers have many of the same personality characteristics as heroin addicts, an Australian study shows. Involved in a study conducted by researchers from the psychiatric unit of the Prince of Wales Hospital, Radwick and St Vincents Hospital, Darlinghurst, New South Wales, were 60 male pathological gamblers seeking behavioral treatment for their condition, 25 male and 26 female heroin addicts attending an out-patient methadone clinic, and a similar number of control patients of both sexes with unrelated disorders. The participants in the study completed the Eysenck Personality Questionnaire (EPQ) and were ranked on the scales in the questionnaire as well as on a 32-item 'addiction scale' derived from the EPQ by Gossop and Eysenck. This scale had differentiated poly-drug addicts from normal controls in a previous test. Results showed that both male heroin addicts and the compulsive gamblers had significantly higher scores on the addiction scale when compared with male controls, but did not differ from each other. They also scored higher on the neuroticism and psychoticism scales of the test. The female heroin users also scored higher on the addiction and psychoticism scales than their respective controls. The researchers note that items composing the addiction scale used are biased highly toward anxiety and depressive effect, which might mean the similarities shown "reflect a general factor of affective disturbance and not a factor specific to addiction." But, they said, if their results can be replicated, it will strengthen the concept of pathological gambling as an addictive disorder.

British Journal of Addiction, Sept, 1985, v. 80:315-319.

Pat Rich

Radio course on addictions takes to the air this month

By Elda Hauschildt

TORONTO — A 20-class radio course on addictions, believed to be the first of its kind in the field, begins here this month.

People living within a 100-mile radius of Toronto can tune in each week to a series of one-hour programs on the social, medical, and legal aspects of alcohol and other drugs.

The course, Drinking and Drugs: Use and Abuse, is offered by Ryerson Polytechnical Institute in cooperation with Ontario's Addiction Research Foundation (ARF) here. It is broadcast by Open College, an educational service of Ryerson's FM radio station, CJRT.

Registered students who listen in each week until June, complete eight written assignments, and attend a seminar day at Ryerson, will earn course certificates. Their $90 tuition fees cover texts, workbooks, and tutoring.

But, registered students are just one target group for the course, says sociologist Ken Radway, a training officer with the ARF's School for Addiction Studies.

"CJRT has approximately 175,000 listeners and about 15,000 of them are regular Open College listeners. It's that general group we are also hoping to reach."

CJRT draws its listeners from an area with the highest population density in Canada and from northern New York state in the United States.

Its audience for the addiction series is expected to include teachers, parents, social workers, and people in personnel.

"We're offering an overview of the alcohol and drug field," Mr Radway told **The Journal**, "a little of everything."

The series starts with a history of drugs and drug abuse. Basic pharmacology, theories, and consequences of drug abuse will be covered in subsequent hours. Various drugs — tobacco and caffeine, alcohol, marijuana and cocaine, and other drugs — will be discussed in individual programs.

"Then, we'll look at drugs in the context of the family: one program on how drug abuse affects individual family members and another on drugs and young people," Mr Radway said.

Alcohol and other drugs as they affect women, the elderly, and employees are other topics in the series, as are legal issues, drinking and driving, compulsive behavior, social policy, health promotion, and treatment.

Students who register for the study course will be tutored by volunteers from ARF staff.

Each of the 20 programs will be broadcast Tuesday afternoons and repeated Thursday evenings. Each will follow the same format, a 15- to 20-minute introduction of the topic by Mr Radway and detailed information from experts.

Radway: the station attracts 175,000 listeners

Link identified with alcohol, heroin abuse

Adult-onset epilepsy risk studied

CHICAGO — Alcoholism and heroin abuse are among the leading risk factors for the development of adult-onset epilepsy.

And, marijuana use seems to be a protective factor in heroin abusers, says a study by Allen Hauser, MD, and colleagues at Columbia University school of medicine, New York.

Hypertension, head trauma, and increasing age are other important risk factors identified in the study.

"There was a very strong association with alcohol and heroin abuse," Dr Hauser, professor of neurology and epidemiology, said at the annual meeting here of the American Neurological Association.

"We're not talking about alcoholic withdrawal seizures. Anyone who has those is by definition an alcoholic. We're talking about the development of epileptic seizures in adults who have previously never had an epileptic seizure.

"The finding that marijuana seems to protect against the development of epilepsy in people otherwise at high risk was very interesting. We can't explain it."

Marijuana use tended to be more prevalent in younger individuals and there was a large overlap between heroin abuse and marijuana use.

"Heroin abusers who also used marijuana were clearly at lower risk," Dr Hauser said.

"Interestingly, there wasn't nearly as tight an overlap between alcohol abusers and heroin abusers. These seem to be two quite distinct populations. There also was very little overlap between alcoholism and marijuana use. But, the protective role marijuana use seems to play in heroin abusers is intriguing and definitely worthy of further study."

Dr Hauser and colleagues used a case-control study of 315 patients with first seizures. Each patient was matched by age, sex, and race to a control patient admitted to hospital for a condition other than first seizures.

Dr Hauser believes a case-control study is the most reliable type of study to determine risk factors for a given medical condition. Detailed information was obtained from study and control subjects on previous medical history, family history, alcohol and other drug use, smoking, and head trauma. "The risk factors we identified were the significant ways in which the two groups differed," he added.

Familial smoke hits asthmatic kids

VANCOUVER — Lung-function tests on asthmatic children show the disease is worse if their mothers smoke, but not if their fathers do. And, the more the mothers smoke, the worse are the effects.

Andrew B. Murray, MD, pediatrics professor at the University of British Columbia, reported on tests of 94 asthmatic children aged seven years to 17 years, at the annual meeting here of the Canadian Paediatric Society.

Children of smoking mothers had 47% more symptoms. Their mean FEV_1 (the forced expiratory volume in one second) was 13% lower, indicating the large airways were narrowed, and their mean maximal mid-expiratory flow rate was 23% lower, indicating the small airways were also narrowed.

A histamine test for bronchial hyperirritability showed their bronchi were more irritable: they could tolerate only 0.5 milligrams of histamine, while the other children could tolerate 2 mg.

Children older than 11 years were more severely affected, possibly because of increased damage to the lungs with more years of exposure to cigarette smoke.

NEWS AND COMMENT

Doctors want peer review first in R_x offences

HALIFAX — A double-doctoring scandal in Nova Scotia has prompted serious soul-searching within the medical profession here, although no physicians faced criminal charges as a result.

At the annual meeting here of the Medical Society of Nova Scotia, after a briefing on the investigation, doctors expressed concern about the need for the profession to show it was capable of policing itself (**The Journal**, April, 1985).

At the beginning of 1985, the drug section of the Royal Canadian Mounted Police (RCMP) here, released a report stating that some 146 physicians (predominantly in the Halifax-Dartmouth area) had been prescribing narcotics to 14 known drug abusers. More than 1,100 prescriptions had been handed out in the year-and-a-half ending June, 1984. Half of the 35 doctors investigated were found to have provided most of the prescriptions.

George Saunders, MD, the society's representative on the provincial medical board, which is responsible for discipline matters concerning physicians, said the board was requested by the RCMP not to investigate three of the doctors involved because the RCMP were planning to lay criminal charges.

Dr Saunders: "After many months, the board was notified that prosecution would not proceed because of the Limitation of Action Act in Nova Scotia."

By this time, one of the three doctors had died, he said, and disciplinary hearings are just now taking place for the other two. A further two physicians have had their names placed on the Narcotic Restricted List by Canada's Bureau of Dangerous Drugs.

Of the other 18 physicians considered to be primarily involved in the double-doctoring situation, Dr Saunders said investigation by the board showed none of the cases were "terribly serious." In many cases, he said, it appeared young doctors were trying to treat drug addicts themselves and got into trouble because of "naivety and inexperience."

What upset outgoing society president Mervin Shaw, MD, about the situation was that by not laying charges, the RCMP made it look as if the society had the power to control the police in this matter.

Dr Shaw: "Our stand has always been that if doctors are guilty of illegal prescribing habits, they should certainly be prosecuted."

Medics bored by smoking debate?

HALIFAX — Doctors in Nova Scotia have joined their *confrères* across Canada in declaring war on tobacco.

In resolutions passed here at the annual meeting of the Medical Society of Nova Scotia, they made it clear that doctors who smoke will be a prime target.

As a result of recommendations made by Donald Fay, MD, society representative on the provincial council on smoking and health, Nova Scotia doctors declared smoking to be a drug addiction "that should be dealt with in the same fashion as drug and alcohol abuse."

Another resolution stated that the medical society's committee on drug and alcohol abuse will provide personal counselling to doctors who smoke to help them break the habit.

Lack of debate on this — and other anti-smoking resolutions — seemed to reflect accurately Dr Fay's comment that people are becoming bored with the smoking problem.

However, he said the problem is still of such magnitude that nobody can afford to be bored with it.

GILBERT

A seven-year soap box

While writing my last column, I was looking through earlier material and noted to my amazement that this month would be the seventh anniversary of the start of these columns in January, 1979.

The series began tentatively, both on my part and on that of the administration of the Addiction Research Foundation (ARF).

My fears were soon dispelled. I have been given an almost totally free hand by the editor. A column has been edited for content just once. The ARF's lawyer recommended holding back a piece because it was in technical contravention of the British Official Secrets Act. (Nine months later, in May, 1983, I used the same material without intervention.) Only once in the seven years has a disclaimer appeared dissociating the ARF from my views — in April, 1981, with the last of a series advocating the legalization of marijuana.

Editing for style occurs every month. My sometimes convoluted prose has been in good hands.

The ARF administration may still have its fears. My columns survive, I like to think, because the ethos of the organization is basically that of the scientific community, which encourages criticism, rather than that of an advocacy group, which stifles dissent.

The columns have reflected my interests in the drug field. These are chiefly the normal and near-normal use of popular drugs — alcohol, caffeine, and nicotine — and the medical and social consequences of this use.

I can categorize the 78 columns I've written chiefly according to which drug I focused on — alcohol (27 columns), nicotine (22 columns), and caffeine (eight columns). Six columns have been on other psychotropic substances — marijuana, solvents, and khat. Fifteen columns have concerned many drugs or substances, or have been on general topics. (See below.)

I have enjoyed writing these columns, and hope to continue for as long as I have things to write about. I have nightmares when I am a week from deadline without an idea in sight. I feel guilty when I knock off a column in an hour or two, but then I push the guilt aside by remembering the many pieces that have required dozens of hours. But, mostly the experience has been good.

Above all, these columns have been a way for me to stay in touch with the sober academic and professional worlds while I spend all too many years of my life immersed in the myriad of vital trivia at City Hall. (*Ed note: Dr Gilbert spends most of his days being a member of Toronto City Council and the Metro Toronto Council.)*

The responses of readers have been mostly a comfort. **The Journal** seems to have lost no more than a few subscribers on account of positions I have taken in defence of tobacco advertising, legalized marijuana, and other anathemas of the drug abuse industry.

Readers moved to write to me about something in one of these columns should obey the impulse. Comments and even requests are most welcome. I may take a month, or two or three, to reply — much too slow a response for student correspondents looking for easy leads into a thicket of research findings: *"May I have your research notes real soon,"* wrote one anxious sophomore from Missouri, *"I must finish my assignment by* [the day before I received the letter], *and you are the only one who can help me."*

May I have your research notes real soon?, wrote one sophomore

I have tried hard to stay close to the research literature, mostly branching out only where relevant findings are few. Much of what has been taken for original expression here has been borrowed from the discussion sections of academic articles — the few sentences of speculation reluctantly permitted by editors to give flair to dry-as-dust data.

Most of these recondite sources of inspiration fall short of the famous last sentence of Watson and Crick's seminal article in *Nature* outlining the double-helix model of DNA: *"It has not escaped our notice that the specific pairing we have postulated immediately suggests a possible copying mechanism for the genetic material."* Nevertheless, these nuggets have served me well in my search for things to write about.

I looked for trends in my columns but found little to comment on, except that their average length has increased through the years — perhaps to the point of discomfort for some readers. Regular readers will have noticed certain themes, particularly in the areas of alcohol and tobacco use.

Alcohol themes:

- Per capita alcohol consumption in Ontario and Canada ceased rising in the mid-1970s.
- Heavy alcohol use is associated more with private than with public drinking.
- Moderate alcohol use may be beneficial in comparison with none at all, but teetotallers may be unusual enough to make this difference meaningless.
- Price is by far the most potent weapon in altering society's alcohol use.
- The way to combat drinking and driving is to put the blame on people who ply alcohol to drivers or who allow drinkers to drive in a condition of drug-induced recklessness.
- It would be better to raise the driving age to 21 years than to raise the drinking age.

Tobacco themes:

- The net costs to society of smoking are not huge: the early deaths of most smokers save us just about as much as the smokers cost us in medical bills, sick leave, and fire damage while they are alive.
- Raising prices is the best way to reduce tobacco use. Nicotine gum is a good adjunct to quitting.
- Quitting smoking produces immediate benefits that should be used to reinforce quitting.
- Curbing tobacco advertising may do nothing for tobacco consumption, but a great deal for our notions of freedom of expression.
- Per capita cigarette consumption rose continuously in Canada until 1982, when real prices began rising and consumption began falling.
- The proportion of smokers had been declining, but continuing and new smokers more than compensated by smoking even more cigarettes. Tobacco consumption remained roughly constant, however, because the weight of tobacco per cigarette declined.
- It is now clear — but only since 1983 — that chronic exposure to second-hand smoke is bad for your health. Smoking is much worse.
- Efforts to curb public smoking should focus on the workplace, where millions are prisoners of other workers' smoke.

Following is a list of all my columns by subject category. Please write to me at **The Journal** if you would like a copy of any previous column.

Alcohol use and abuse:

Alcohol consumption will decline in 1979 (Jan 79); Public and private drinking (April 79); Are alcoholics different from you and me? (July 79); Views on Alcoholics Anonymous (Aug 79); Lower the legal limit (Dec 79); Alcohol consumption during 1979 (Jan 80); Breathtesting: loophole in the Criminal Code (Feb 80); Alcohol can be good for you (March 80); Can we ever hope to stop alcohol abuse? (April 80); What do we do about alcohol? (May 80); Firth vs Whitehead — unanswered questions (Nov 80); The main problem of alcoholism (Dec 80); The facts on alcohol (June 81); Drinking and driving: I (July 81); Drinking and driving: II (Aug 81); Tippling and toping (Oct 81); Is drinking and driving really a problem? (Feb 82); A licence to drink (March 82); Boozewords: a brief history (Jan 83); A not-so-secret report (May 83); Beverage futures (June 83); The drinking age debate (Sept 83); Optimal alcohol use: I (Dec 83); Optimal alcohol use: II (Jan 84); Doubts about moderate alcohol use (Dec 84); Blame the host (March 85); and, Beer, wine, and groceries (Nov 85).

Tobacco use and abuse:

Snuffing the myths of second-hand smoke (Feb 79); Should we try to prevent drug abuse? (June 79); Why do people smoke? (Oct 79); A case for tobacco advertising (Nov 79); Is tobacco North America's No. 1 preventable cause of death? (June 80); 'Smokers should try some . . .' (July 80); The benefits of quitting smoking: I (Sept 80); The benefits of quitting smoking: II (Oct 80); The costs of smoking (Sept 81); Smoking research at ARF (Nov 81); A sure way to reduce cigarette use (April 82); Another sure way to reduce cigarette use (May 82); Stopping young people from smoking (July 82); Smoking and health in Ontario (Oct 82); Tobacco research at the ARU (March 83); Smoking control efforts (July 83); Smoking and the workplace (March 84); The tobacco industry is right (May 84); Cigarette weights (July 84); Women, cigarettes, and advertising (Aug 85); Passive smoking: I (Sept 85); and, Passive smoking: II (Oct 85).

Caffeine use and abuse:

Caffeine and pregnancy (May 79); Caffeine consumption (Aug 80); Caffeine and myopia (Feb 83); Coffee and opiates (Aug 83); Caffeine consumption (Nov 83); Caffeine — history, habits, and health: I (Sept 84); Caffeine — history, habits, and health: II (Oct 84); and, Caffeine, endurance, and weight loss (Dec 85).

Marijuana, solvents, and khat:

The fourth most popular drug (Feb 81); Marijuana: Scylla and Charybdis: I (March 81); Marijuana: Scylla and Charybdis: II (April 81); Solvent abuse (Oct 83); Khat: history, chemistry, and pharmacology (April 85); and, Khat: use and abuse (June 85).

Many drugs/general topics:

Costs and benefits of drug abuse (March 79); Energy dependence: does science have a cure? (Sept 79); Forty-three theories of drug abuse (May 81); Science, statistics, and ethics (Dec 81); Experimenting with humans (Jan 82); Drug abuse in 1992 (June 82); Scientific intentions (Aug 82); Conditioned responses and drug abuse (Sept 82); Science and journalism (Dec 82); Britain's Addiction Research Unit (March 83); More about beverage marketing (June 84), Journalistic practice (Aug 84); Patterns of drug consumption (Nov 84); Microcomputers (Feb 85); and, A community free from avoidable cancer (July 85).

By Richard Gilbert

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Cigarettes are not pure profit

Tobacco stats stack up

An article entitled Stats•facts (November, 1985) reported that the Canadian government received $2.2 billion directly from tobacco sales.

The reader is left with the impression that this is pure profit. However, Neil Bradshaw and Byron Rogers (*Canadian Pharmaceutical Journal*, 1984, v.4:117-150) show a startling profit-loss contrast.

In 1982, total consumer expenditure for tobacco products was $4.42 billion (including the $2.2 billion in taxes mentioned in the article); the cost to Canadians in the same year, including lost income due to mortality, disability, hospitalization, and physician costs was $7.12 billion.

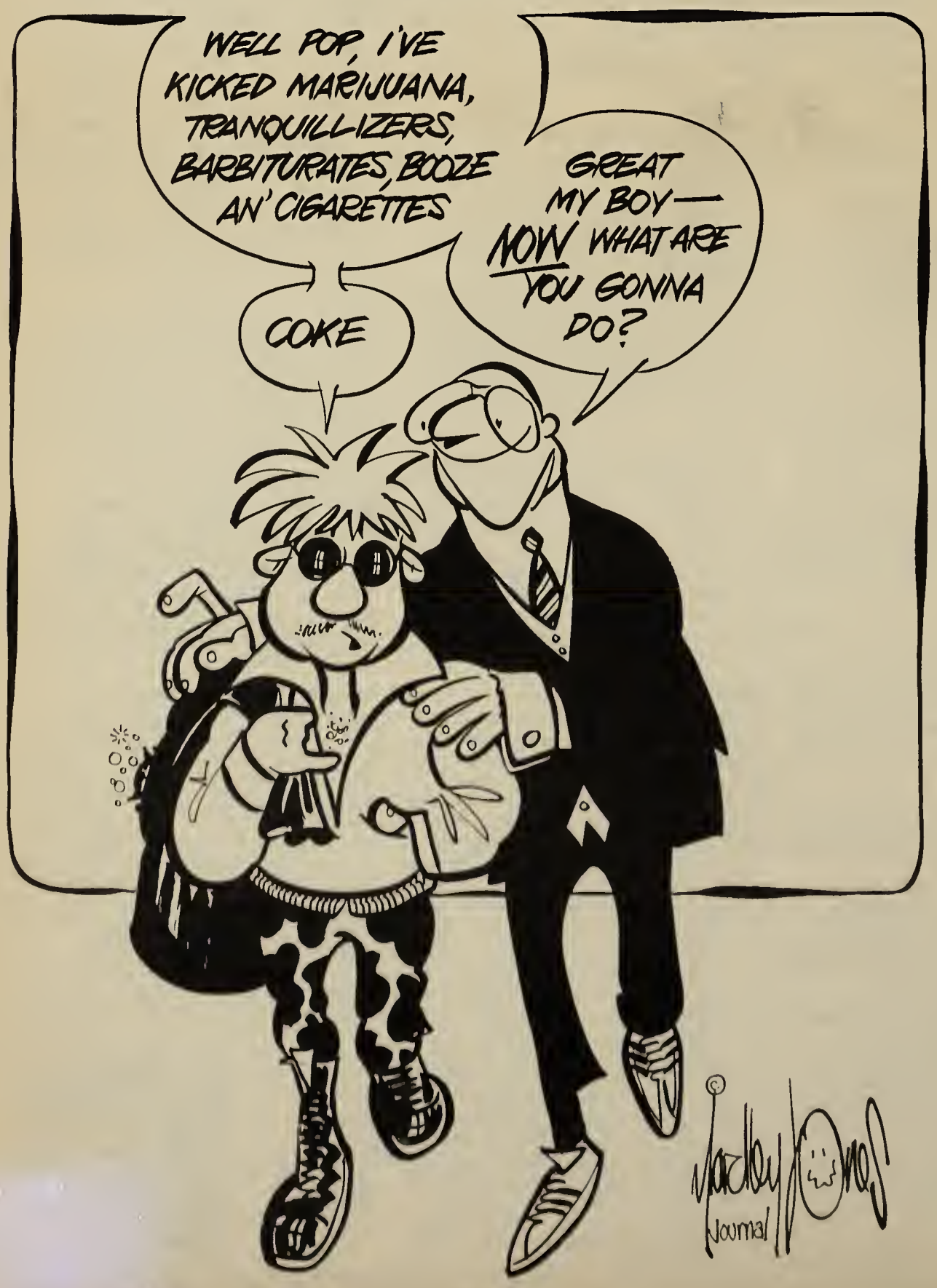
This would be even higher if one were to include costs associated with passive smoking and fighting fires caused by careless smoking.

STATS·FACTS

These costs result in a net loss to Canadians of $2.7 billion. With such dramatic health and financial implications to our country, one wonders why tobacco is still a legal product in Canada.

I enjoy reading **The Journal** and find it a very valuable and informative document.

Brian C. Stocks
Executive Director
The Lung Association
(Essex County Region)
Windsor, Ont



MDs do know, but ...

Wayne Howell's plaint about the "doctors know nothing about alcoholism" theme (October, 1985) only perpetuates the basic fallacy which runs through most of these discussions.

He fails to distinguish clearly between the medical effects or complications of alcoholism, such as cirrhosis, and alcoholism as a primary illness. Yes, doctors know all about cirrhosis. Unfortunately, far too many of them (not all) are still not well trained in diagnosing and handling alcoholism itself.

This is amply testified to by the daily experience of those of us who work with alcoholics. But, the situation is improving, and this is meant as a clarification, not a complaint.

James E. Royce
Professor of Alcohol Studies
Seattle University
Seattle, Wash

ICAA luncheon featured Ms Ferrence too: reader

The 34th International Conference (of the International Council on Alcohol and Addictions) in Calgary was an event of which Canadians can be proud because it was so well-conducted and was the first in this series to be held in Canada. I am sure that countries and organizations were proud of their members who made presentations and participated in other ways.

The September, 1985 issue of **The Journal** provided some coverage, and more was published in the October issue. The highest profile event at the conference was the Women and Addictions Luncheon. It was a standing-room-only affair that featured Betty Ford, of whom mention was made in the September issue. When are you going to get around to reporting that Roberta Ferrence, a researcher with the Addiction Research Foundation in Ontario also spoke and had something of substance to say to that large audience? A few words about that presentation might also be in order.


Ford


Ferrence

Paul C. Whitehead
London, Ont

Nicotine use not abuse?

The Journal may be outliving its usefulness. To advocate tobacco's eradication is ridiculous (November, 1985). Nicotine use is not drug abuse, and, in fact, may be just the opposite. Smoking may promote emotional calm and stability, an effect quite opposed to stimulation. This same principal applies to caffeine.

Another tragic farce will be Canada's legalized heroin prescription use. This use of such a short-acting opiate with a very high tolerance is asinine. Why not use Dilaudid (hydromorphone), even more pleasurable to many addicts, and it could be taken orally? This would be just as idiotic.

The productivity of an entire nation relates directly to the extent of prevalent substance abuse, including alcohol and, particularly, marijuana, but excluding nicotine and caffeine.

I cherish my photo of Winston Churchill at the age of 80 years with a big fat cigar in his mouth and a highball in his hand.

Alfred V. Miliman
Director
Maryland Drug Abuse Research and Treatment Foundation, Inc
Baltimore, Md

Reader praises balanced stories

Keep up the good reports. **The Journal**, at least, gives its readers balanced reporting, as compared to the lay press, which pretty well conceals the deadly reality of popular recreational drugs, such as alcohol, while seeking out the worst cases of use of other drugs and making it appear that every user of a non-approved drug is going to hell in a hand basket.

R. L. Foster
Burnably, BC

The Journal's 1986 calendar

1986 CALENDAR

International Year of Peace — 1986

1986

The Journal

JANUARY

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

MARCH

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
			PRIDE 1986 International Conference on Drugs, Atlanta, March 19-22			
23/30	24/31	25	26	27	28	29

APRIL

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
International Institute on the Prevention and Treatment of Drug Dependence (ICAA), Amsterdam, April 6-11						
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10 American
11	12	13	14	15	16	17
Psychiatric Association Annual Meeting, Washington, May 10-16 →						
18	19	20	21	22	23	24
				PRIDE CANADA Conference —Youth and Drugs, Saskatoon, May 22-24		
25	26	27	28	29	30	31

JUNE

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
International Institute on the Prevention and Treatment of Alcoholism (ICAA), Budapest, June 1-6						
8	9	10	11	12	13	14
15	16	17	18	19	20	21
	Committee on Problems of Drug Dependence, Tahoe City, June 16-18					
22	23	24	25	26	27	28
29	30					

JULY

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Institute on Addiction Studies, Hamilton, July 13-18

Summer School for Addiction Studies, Addiction Research Foundation, Toronto, July 14-25

AUGUST

SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

SEPTEMBER

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Cdn Psychiatric Assoc Mtg, Vancouver, Sept 24-25

OCTOBER

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOVEMBER

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24	25	26	27	28	29

DECEMBER

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Alcohol and Other Drugs: You and Your Family — Radio course, begins Jan 6. Information: Ryerson Open College, 297 Victoria St, Toronto, Ontario M5B 1W1, or School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Addiction Intervention Association Inaugural General Meeting — Jan 23, Scarborough, Ontario. Information: Russ Pickering, president, Addiction Intervention Association, 6 Margrath Place, Etobicoke, ON M9C 4L2.

Ontario Psychiatric Association Annual Meeting — Jan 23-25, Toronto, Ontario. Information: Ontario Psychiatric Association, 1528A Dundas St W, Toronto, ON M6K 1T5.

Rights — And Wrongs: Police Powers of Arrest, Search, and Seizure in Drug Cases — Jan 28, Toronto, Ontario. Information: Special Events, Addiction Research Foundation, 33 Russell Street, Toronto, ON M5S 2S1.

Canadian Society of Hospital Pharmacists 17th Annual Professional Practice Conference — Feb 3-5, Toronto, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

The Street is No Place for a Kid: Symposium on Street Youth — Feb 10-12, Toronto, Ontario. Information: 1st Annual Symposium on Street Youth, Covenant House, 70 Gerrard St E, Toronto, ON M5B 1G6.

Ontario Psychological Association Annual Meeting — Feb 13-15, Toronto, Ontario. Information: Mona Abbott-Kesting, administrative officer, OPA, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

Health Promotion Workshop —Feb 24-26, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Relaxation and Stress Management Workshop — March 6-7, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

National Consultation on Women and Drugs — May 12-15, Geneva Park, Ontario. Information: K. Madden, health promotion directorate, Health and Welfare Canada, Rm 449, Jeanne Mance Bldg, Tunney's Pasture, Ottawa, ON K1A 1B4.

Youth and Drugs, PRIDE CANADA Conference — May 22-24, Saskatoon, Saskatchewan. Information: Eloise E. Opheim, PRIDE CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Ontario Medical Association 106th Annual Meeting — June 9-12, Toronto, Ontario. Information: annual meeting coordinator, OMA, 250 Bloor St E, Ste 600, Toronto, ON M4W 3P8.

86th Annual Meeting of the Canadian Lung Association — June 13-16, Winnipeg, Manitoba. Information: A. Les McDonald, director of health education and program services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

77th Annual Conference of the Canadian Public Health Association — Health Promotion Strategies for Action — June 16-19, Vancouver, British Columbia. Information: CPHA, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

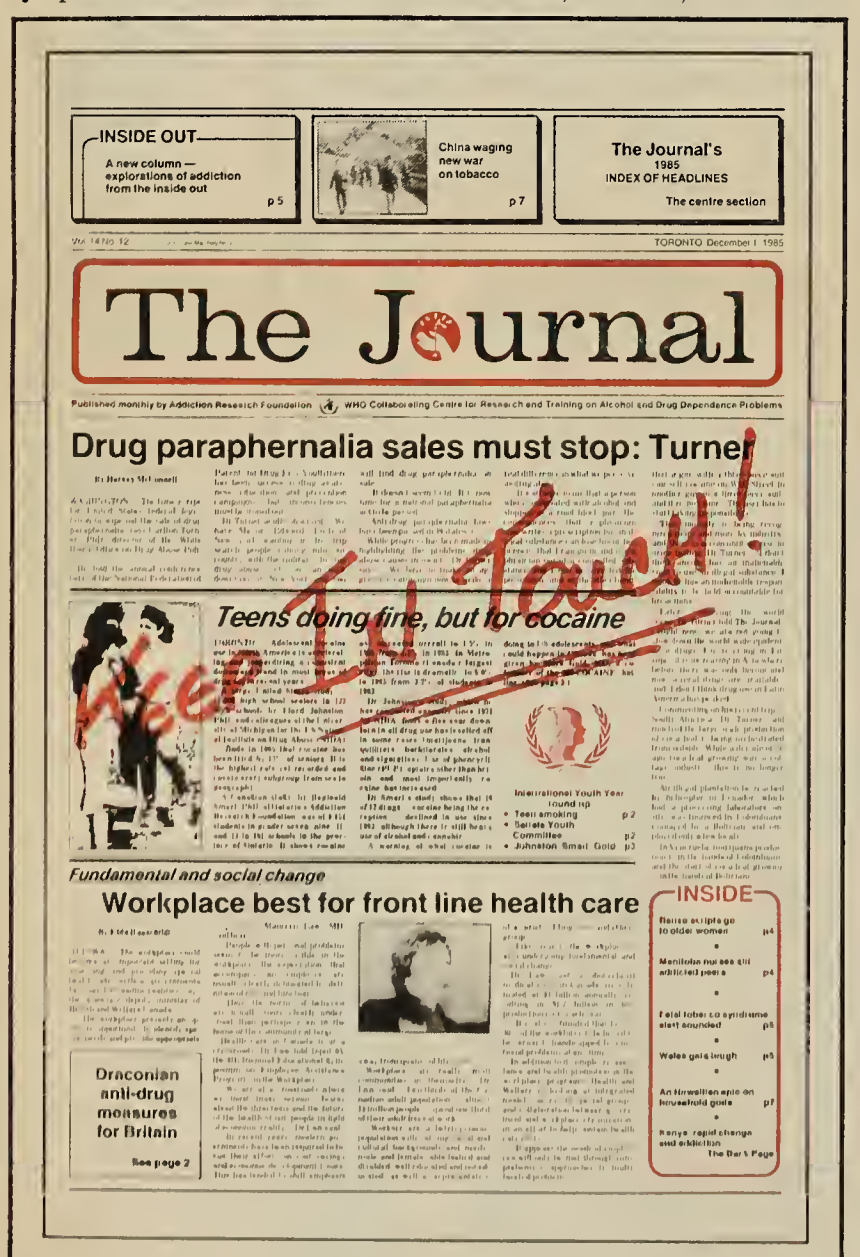
27th Annual Institute on Addiction Studies — July 13-18, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School for Addiction Studies — July 14-15, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Society of Hospital Pharmacists 39th Annual Meeting — August 28-30, Ottawa, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

Social Services Federation of Canada: Research 86 — Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario, K1A 0N5.


INSIDE OUT
A new column — explorations of addiction from the inside out p5

China waging new war on tobacco p7

The Journal's 1985 INDEX OF HEADLINES
The centre section

VOL 14 NO 12 TORONTO December 1 1985

The Journal

Published monthly by Addiction Research Foundation — WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Drug paraphernalia sales must stop: Turner

Teens doing fine, but for cocaine

Fundamental and social change

Workplace best for front line health care

INSIDE
Nurses exempt age to older women p4
Manitoba nurses still arbitrated pacts p4
Fatal lobe co syndrome alert sounded p5
Wales gets tough p5
An Hmwellian epic on household goals p7
Kenya rapid change and addiction
The Dark Page

Draconian anti-drug measures for Britain
See page 2

United States

2nd Annual National Convention on Children of Alcoholics — Feb 23-27, Washington, DC. Information: US Journal of Drug and Alcohol Dependence, Inc, national convention coordinator, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

International Congress and Exposition — Alcohol, Accidents, and Injuries — Feb 24-28, Detroit, Michigan. Information: National Highway Traffic Safety Association, 400 7th St SW, Washington, DC 20591.

Substance Abuse Seminar — A National Problem: Prevention and Rehabilitation — March 12, New York, NY. Information: Association for Children with Learning Disabilities 1986 Conference, 4156 Library Rd, Pittsburgh, Pennsylvania 15234.

American Pharmaceutical Association — March 15-20, San Francisco, California. Information: American Pharmaceutical Association, 2215 Constitution Ave, NW, Washington, DC 20037.

PRIDE 1986 International Conference on Drugs — March 18-22, Atlanta, Georgia. Information: PRIDE (National Parents' Resource Institute for Drug Education, Inc), 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

SECAD-West — Current Trends in Addiction — April 3-6, Denver, Colorado. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, Addictive Disease Division, 11050 Crabapple Rd, Ste D-120, Roswell, Georgia 30075.

American College of Physicians Annual Meeting — April 10-13, San Francisco, California. Information: Robert Moser, executive vice-president, 4200 Pine St, Philadelphia, Pennsylvania 19104.

American Medical Association's 7th National Conference on the Impaired Physician — April 11-13, Chicago, Illinois. Information: Janice Robertson, AMA media relations department, 535 N Dearborn St, Chicago, IL 60610.

American Medical Society on Alcoholism and Other Drug Dependencies and the Research Society on Alcoholism — Joint Meeting — April 18-22, San Francisco, California. Information: AMSAODD-RSA Meeting, 12 W 21st St, New York, NY 10010.

3rd National Conference on Alcohol and Drug Abuse Issues in Higher Education — April 27-29, San Antonio, Texas. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St NW, #181, Washington, DC 20001.

NECAD 86 — May 4-7, Newport, Rhode Island. Information: Jane Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Rd, Newport, RI 02840.

American Psychiatric Association Annual Meeting — May 10-16, Washington, DC. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

American Lung Association, Annual Meeting — May 11-14, Kansas City, Missouri. Information: James A. Swomley, managing director, 1740 Broadway, New York, NY 10019.

1986 National Association of Social Workers National Conference on Women's Issues — Dangers and Opportunities: What's Ahead for Women? — May 28-31, Atlanta, Georgia. Information: NASW conference planning committee, 7981 Eastern Ave, Silver Spring, Maryland 20910.

International Drug Development in the 21st Century — 22nd Annual Meeting, Drug Information Association — June 1-5, Washington, DC. Information: Drug Information Association, PO Box 113, Maple Glen, Pennsylvania 19002.

American Society of Hospital Pharmacists — June 1-5, Denver, Colorado. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

48th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 16-18, Tahoe City, California. Information: Mary Jeanne Kreek, Committee on Problems of Drug Dependence, Inc, The Rockefeller University, 1230 York Ave, New York, NY 10021.

National Clergy Council on Alcoholism and Related Drug Problems Annual Meeting — June 16-20, Chicago, Illinois. Information: John O'Neill, executive director, 3112 7th St NE, Washington, DC 20017.

17th Annual Narcotic Research Conference — July 6-11, San Francisco, California. Information: E.L. Way, dept of pharmacology, University of California, San Francisco, CA 94143.

North American Congress on Alcohol and Drug Problems — Sept 7-11, Boston, Massachusetts. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St NW, #181, Washington, DC 20001.

Association of Labor-Management Administrators and Consultants on Alcoholism — Nov 1-5, Dallas, Texas. Information: ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

American Association for Advancement of Behavior Therapy Annual Meeting — Nov 13-16, Chicago, Illinois. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

Abroad

The International Conference on Drug and Alcohol Abuse — Jan 15-17, Freeport, Grand Bahama. Information: R.R. Travel Agency, 3719 E. Frank Phillips Blvd, Bartlesville, Oklahoma 74006.

15th International Institute on the Prevention and Treatment of Drug Dependence — April 6-11, Amsterdam/Noordwijkerhout, The Netherlands. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

2nd Annual International Industrial Alcoholism Symposium — May 20-22, Frankfurt, Germany. Information: Annette Stappert, conference coordinator, Conecta, 12 Stooter St, 4330 Mulheim 13, Germany.

32nd International Institute on the Prevention and Treatment of Alcoholism — June 1-6, Budapest, Hungary. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

3rd Congress of the International Society for Biomedical Research on Alcoholism — June 8-13, Helsinki, Finland. Information: Sari Salo, 3rd ISBRA Congress, Alko Ltd, PO Box 350, SF00101, Helsinki, Finland.

International Symposium on Health Education in Schools —July 6-10, Jerusalem, Israel. Information: D. Tamir, International Symposium, PO Box 394, Tel Aviv 61003 Israel.

International Sociological Association World Congress — August 13-18, New Delhi, India. Information: Alex C. Michalos, University of Guelph, Guelph, Ontario, N1G 2W1.

14th International Cancer Congress — Aug 21-27, Budapest, Hungary. Information: Crimson Travel Service, 39 John F. Kennedy St, Cambridge, Massachusetts 02138.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

10th Conference of the International Committee on Alcohol, Drugs, and Traffic Safety — Sept 9-12, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

International Symposium on Young Drivers' Alcohol and Drug Impairment: Selective Countermeasure Program Development — Sept 13-15, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, dept of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

NEWS

At the moment, there's no help at all, says psychiatrist

WHO-sponsored surveys locate Kenyan addicts

By Joan Hollobon

NAIROBI — Alcohol and other drug abuse have exploded into a problem in less than a decade in Kenya.

Wilson Acuda, MD, professor and chairman of the department of psychiatry at the University of Nairobi, told **The Journal** that prior to 1976 or 1977 little was heard about it.

"Up to 1976 or 1977, you weren't hearing much in the media, or from opinion leaders expressing concern, or from teachers complaining. And, doctors weren't seeing much. But, from that time, it has become a problem, and it seems to be increasing — hardly a day passes without some article in the press," Dr Acuda said.

Drugs involved are primarily tobacco, alcohol, cannabis, khat, and benzodiazepines. Heroin or other opiates are relatively uncommon. Dr Acuda: "When we come across them, it is usually among tourists. It is common for us to get a call from a private hospital saying they have a tourist who is addicted, can't get it (the drug), and is having a withdrawal problem."

Khat, usually called *miraa* in Kenya, is a plant chewed for its psychostimulant effects, similar to those of amphetamines (**The Journal**, June, May, 1985).

Dr Acuda, also a consultant in psychiatry at Kenyatta National Hospital here and at Mathari Psychiatric Hospital, has been involved in some of the few surveys on alcohol and other drug abuse carried out in East Africa. These surveys were supported mainly by the World Health Organization (WHO) and the United Nations.

He is a member of the WHO's panel responsible for collecting information, and his department is engaged in WHO collaborative studies aimed at developing simple techniques for the detection and management of early alcoholism.

In a review of alcohol use in East Africa published in the *British Journal of Addictions* (June, 1985), Dr Acuda said: "Despite very heavy consumption of alcohol in the region, very little research has been done to date on the problem," mainly owing to lack of money, staff, and facilities for data processing or laboratory tests.

Another difficulty is that record keeping is usually incomplete because patients frequently change their names and addresses. The lack of a forum for publication and exchange of ideas often results in research workers in, say, Kenya, having no idea of comparable work going on in Tanzania.

Several surveys were carried out, however, following a public outcry of concern in Kenya in 1978 by community leaders about alcoholism and other drug use.

Dr Acuda said the first survey was in a rural area where a study of 200 randomly-selected households turned up a heavy rate of alcoholism. Some 27% of men and 24% of women could be classified as alcoholic (using the WHO 1952 definition, ie drinking excessively and showing noticeable physical, mental, or social disturbances).

Using the same questionnaire, the team then studied a "squatter area," an over-populated slum district of Nairobi where nearly 100,000 people live crammed onto 490 acres of land.

Here, up to 46% of the male and 24% of female household heads interviewed were classified as alcoholic.

Dr Acuda said a survey of youth between 10 years and 29 years was conducted here in 1983 and in a rural area.

While 67% of the boys and 48% of the girls interviewed admitted ever taking alcohol, only 11% of boys and 4.1% of girls "could be classified as abusers or regular users of alcohol (three or more days a week)."

The report showed that the tendency to abuse alcohol increased with age: abuse by those less than 19 years of age was 8%, by those 20 to 24 years old was 14%, and by those older than 25 years was 21%. Alcohol abuse was most prevalent (14%) among poor youth, less among the affluent (5%), and least among the rural youth (3.6%).

Only 5% of youth still attending school were abusing alcohol, compared with up to 17% of those who had left, most of whom were unemployed.

"Cigarette smoking was much higher — I think it was about 17%, and these were the ones we think were having a problem, not just the regular users," Dr Acuda said.

About 6% were taking miraa more than three times a week and about 5% cannabis. Young people

Acuda: hardly a day passes

were also found taking benzodiazepines, particularly diazepam (Valium).

Specialized treatment facilities for alcoholism are non-existent in Kenya. Treatment is mainly confined to the country's few psychiatrists — there are about 12 in Nairobi and three in hospitals outside the city.

Kenya has a population of about 19 million people, one million of them in Nairobi.

The wealthy, or those whose bills are paid by employers, go to one of Nairobi's four private hospitals, where some of the psychiatrists practise.

"It would be much better if there were some other place, because, as you know, a lot of people don't like seeing psychiatrists," Dr Acuda said.

The surveys helped raise awareness of alcoholism, but more is needed. Often, physicians fail to ask patients about drinking habits, and juvenile courts fail to consider alcoholism in the home when dealing with children.

"If we can show that alcoholism is associated with wife battering, violence, educational problems among children, and much of the depressive illnesses and suicide attempts by housewives, we can alert the people who can help and create some sort of facility. At the moment there is no help at all."

NZ politician conducts own survey

Principals report drug concerns

By Tony Garnier

WELLINGTON, NZ — A member of parliament's private survey shows more than half of the secondary schools here have students with drug problems.

The National Opposition spokesman on misuse of drugs, Graeme Lee, says he carried out the survey in a bid to show drug abuse is increasing among young people and to press authorities on the need for a more detailed, thorough attack against it.

He says he was staggered to find that while there is growing concern by society about drug use, there was surprisingly little evidence of what was actually happening.

Of 241 schools responding (392 schools were sent the survey in June, 1985), Mr Lee said 52% indicated pupils had problems with marijuana, ranging to considerable from minimal usage.

Solvent sniffing was reported by 45% of the schools, a fact Mr Lee said underscored the reality that it was not a passing "fad," as some people claimed.

Alcohol abuse was reported to be high, mainly because of its easy availability, he said. Nearly two-thirds of all New Zealand high school pupils were estimated to use alcohol, though it was not reported to be a great problem within the schools themselves.

However, Mr Lee said, principals were not only concerned about the trend to alcohol use/abuse among pupils, but also that many sought help as a matter of priority.

Cigarette smoking was reported by 5% of the schools as their major drug abuse problem, although it was not specifically mentioned in the questionnaire.

Mr Lee said his first recommendation was that the health or education departments undertake a comprehensive survey so the full extent of the problem could be determined and tackled.

Because the questioning in his survey was simple and open to wide interpretation, his results should be accepted as a trend rather than conclusive evidence, he suggested. A more detailed survey would be able to contact pupils directly and thus give educators a better understanding of causes of problems.

On the optimistic side, Mr Lee said his survey revealed there was a majority of young people without drug abuse problems, and this should be regarded as encouraging.

HOWELL

I detected a chill in the room

Every New Year, a regular columnist is faced with a truly vexing question. Should he pass comment on the year just passed, throwing darts at those who have disturbed and flowers at those who have found favor, or should he demonstrate his skills as a futurist by fearlessly predicting the shape of things to come?

Perhaps I should not have chosen a dark and stormy night in December to ponder this problem. Or, perhaps, I should not have begun my contemplations by idly leafing through **The Journal**'s Index for 1985 (December, 1985), noting in passing my various contributions.

In any event, that is what I did, and the consequences were most dire. First, I detected a chill in the room. Then, I heard a clanking of chains. And then, I was faced with the apparition all columnists such as I — columnists who thrive on facetiousness rather than facts — live in mortal fear of: The Ghost of Columns Past.

I had heard somewhere that when one is faced with an apparition of this sort, it is a good idea to cower. So I cowered in a corner for a while, and that seemed to make a good impression. Because, after some minutes passed, a bony finger was pointed in my direction and a disembodied voice commanded: "Get back to that keyboard and get this down — verbatim."

I did what I was told, and, nervously pecking at my word-processor, I produced the following transcript:

The Ghost of Columns Past — What, pray tell, do you perceive your mandate to be?

W.H. — To entertain; to amuse — that, first and foremost.

GHOST *(shaking a sheaf of photo-copies)* — Bah! Humbug!

W.H. *(cowering)* — I know I can't amuse all of the readers all of the time, but if I amuse some of the readers some of the time isn't that enough?

GHOST — Look at this stuff: 12 columns, a whole year's production. I can count the so-called funny ones on the fingers of one hand.

W.H. — Well, I admit that 1985 wasn't a banner year for laughs, but . . . well, I've got my problems too, you know. . . .

GHOST — Don't snivel. And stop that cowering. Get back to the keyboard. You smart-ass columnists are always the same: you can dish it out, you can hurt well-meaning people with your snide remarks and send-ups, but you can't take it.

W.H. *(trying not to snivel or cower)* — Yes, Sir.

GHOST — You know, when I look at this stuff — when I look at these 12 columns — do you know what I see? Do you know what I see?

W.H. *(cowering abjectly)* — No, Sir.

GHOST — Don't "No, Sir" me. You know exactly what I see. I see the beginnings of TTS.

W.H. *(cravenly cowering)* — No, No, not that!

GHOST — Yes, that is what I see — the beginnings of TTS. In at least three of the columns, if not more. Now, are you going to tell these good people about TTS, or shall I?

W.H. — Let me tell it. A good many years ago, when I was writing a column for a daily newspaper, I happened to turn on the radio and I heard another daily newspaper columnist doing an allegedly funny bit about his own toenails; he was describing his problems with clipping, holes in his socks, etc.

Do I have to continue . . . ?

GHOST — Go on.

W.H. — To me, this represented the ultimate in self-indulgence and bankrupt imagination. It appeared to me that that person was reduced to exploiting the most intimate and trivial details of his own life for profit. I vowed that I would never do that, I would never fall victim to the "Terminal Toenail Syndrome" (TTS).

GHOST — Yes, I know that. So how do you explain your May 85 column, your October 85 column, and your November 85 column? All of them excessively personal, none of them in the least bit funny, and all of them going down the road to TTS. You'll be writing about your gerbil next, I suppose.

W.H. — If I can paraphrase Christopher Marlowe, that was in another year, and besides the beast is dead.

GHOST — You've inadvertently introduced another topic for discussion: this self-indulgent habit of making obscure references; you think they're oh-so-clever. As far as I'm concerned, they're just a pernicious variant of the TTS syndrome.

W.H. *(grasping at straws)* — You must admit that the gerbil column was funny.

GHOST — Well, yes, it did have it's moments. And, maybe, there is a lesson in that for you. If you can use personal experience to create an amusing column, then you should use it. But, if you use personal experience as a basis for pontification and philosophizing, then you are on the road to TTS. Mark my word.

W.H. — I'll mark it. And, I'll try to do better in 1986.

GHOST — I hope so. Now, help me out with these chains. I've got a few other columnists to visit tonight; they're a cynical lot, and if I don't come in clanking, I can't even get their attention. Over the left shoulder there — that's it. Thank you kindly. Well, I'll be off now. There's just one other thing — wish every reader a Happy New Year.

W.H. *(cowering, but not quite so cravenly as before)* — Yes, Sir. My Pleasure.

By Wayne Howell

NEWS

High-tech drug sniffer detects contraband cargo

By Thomas Land

LONDON — A combination of a Canadian "super-sniffer" and a powerful British X-ray detection system could be used soon by countries to identify alcohol, other drugs, explosives, and guns sealed in legitimate land, sea, and air freight containers. The examination would take place by remote control while the containers remain sealed.

A complete cargo examination system — which makes use of sophisticated electronics with important military implications (**The Journal**, February 1985; May, 1983) — will cost up to £40 million (Cdn $72 million). The system is likely to emerge as a potent weapon against international drug syndicates and terrorist organizations. It should also speed the flow of commerce and reduce the cost of damage to cargo at customs checkpoints.

Little was known publicly about the rapidly-developing sniffer technology until a description by Neil Reid, PhD, vice-president of Sciex of Thornhill, Ontario, the company producing the vapor sensor for the cargo examination system. To illustrate the sensitivity of the device, he noted "it could detect a single drop of alcohol allowed to diffuse throughout the Astrodome in Houston, Texas — if the stadium were completely sealed."

The growth in use of sealed containers in international transport has made detection of contraband difficult. In most countries, cargo is examined manually and by dogs trained to sniff out drugs and explosives. Manual inspection is slow and cumbersome, involving the unpacking and repacking of goods and, sometimes, causing damage to cargo.

The new high-tech clearance system, developed by the Canadian company in partnership with a consortium led by British Aerospace Dynamics, enables two technicians to examine the contents of up to 40 standard containers an hour — without opening them.

The sniffer detects the presence of contraband in closed containers or vehicles by sampling the air around the cargo shipment. The "nose" inhales odors through the container walls for 60 seconds and then passes the vapors into chambers where they are identified and measured. It seeks out alkaloids, the main substance present in most illicit drugs, and nitrates, the telltale ingredient of explosives.

The device has been developed with a $3.1 million grant from the Canadian defence industry productivity program. It is a sophisticated version of an earlier computer-controlled spectrometer system for the analysis of environmental pollutants, fragrances, and flavors present in foods and vapors of military significance. A variant of the system provides rapid isotopic dilution that can be used to analyze about 90% of the elements in the periodic table, a capability useful for geochemical and nuclear studies and for facilitating the use of stable isotopes in nutritional, agricultural, and biomedical areas.

Dr Reid says the mass spectrometer in the Anglo-Canadian cargo examination system is being further refined in a program that could take another nine years.

The first two orders for the cargo examination systems have come from the Middle East.

A tobacco-less society by year 2000

Government closing in on New Zealand's smokers

AUCKLAND, NZ — An official call for New Zealanders to accept the challenge of a smoke-free society by the year 2000 is the latest in several moves against cigarette smoking in this country.

In his annual report to parliament, Director-General of Health Ron Barker, MD, said accepting such a challenge would mean people should be able to move about public places and at work without being subjected to the unpleasantness and health dangers of second-hand smoke.

He said reducing the level of smoking was probably the single, most important channel by which an improvement in health could be made.

Earlier, Minister of Health Michael Bassett, MD, gave his support to the idea of a council for non-smoking and health — rather like the existing Alcoholic Liquor Advisory Council.

Creation of a national body to oversee promotion of non-smoking was one of a series of recommendations from a government-appointed committee on smoking and health. The committee said its aim is to increase the proportion of non-smokers in the population to at least 80% by 1991.

Other recommendations, including a ban on smoking in confined public places, were made to the government by a medical task force on asthma — a condition with a high incidence in New Zealand.

Pat McCarthy reports

Meanwhile, the government and tobacco companies reached an agreement on tighter restrictions on cigarette advertising and promotion. It incorporates a stronger health warning on packets ("Smoking endangers health") and a ban on promoting cigarettes through free gifts or coupons.

The tobacco industry currently provides $340 million (Cdn $248 million) a year in taxation revenue, and the government spends $419,000 on educating the public against smoking.

Amnesic alcoholics fare well following rehab

AUCKLAND, NZ — Attempts to rehabilitate brain-damaged alcoholics to live in the community may be justified, authors of a study here conclude.

And, there is increased interest in, and knowledge about, the rehabilitation of brain-damaged patients. Rehabilitation programs are inexpensive compared to in-patient care.

The study at Cherry Farm Hospital, Dunedin, involved 14 chronic alcoholics, all considered by staff to have a moderate-to-severe degree of memory impairment.

Four patients undertook an eight-week memory training program, which included practice in learning and recalling visual and verbal information. Six took part concurrently in an active control group designed to provide an equivalent amount of stimulation.

A further four patients received no treatment.

After treatment, both the memory group and the activation control group showed improved memory functioning, and it was hypothesized that participation in either group would be associated with improved rehabilitation status.

At follow-up a year later, two of the four patients in the memory training group and four of the six in the activation control group were discharged from hospital, while all four of the no-treatment group remained as in-patients.

"Recent research has indicated that amnesic patients vary in the degree of their memory deficits and that even severely amnesic patients retain some ability to learn, with preservation of specific learning skills," reported the team of three psychologists led by Hamish P.D. Godfrey.

"Our experience has indicated careful behavioral and neuropsychological evaluation is of use in monitoring the progress and rehabilitation potential of amnesic alcoholics, many of whom can function in the community with varying degrees of supervision."

The study was reported in the *New Zealand Medical Journal* (1985; 98:650-651).

Rare ailment for smokers

AUCKLAND, NZ — Heavy cigarette smoking has been described as a likely pathogenic factor in four women diagnosed with a rare condition of severe, high blood pressure and salt depletion due to narrowing of a kidney artery.

Doctors at Princess Margaret Hospital, Christchurch, said they were surprised to find four such patients in a period of 21 months, as the condition is not mentioned in many standard medical textbooks.

The women were aged from 57 years to 69 years. All had smoked at least 20 cigarettes a day for periods of from 25 years to 50 years, Dr Helen Heslop and colleagues reported in the *New Zealand Medical Journal* (1985; 98: 739-42).

They said recent research had emphasized the relationship between cigarette smoking and the narrowing of the renal artery.

Treatment with converting-enzyme inhibitors (and in one case removal of a kidney) reversed the abnormalities, the Christchurch doctors reported.

Investigators track intestinal tracts of heroin-consuming smugglers

AUCKLAND, NZ — When police and customs officers suspected a man and woman of having swallowed packages of heroin before flying here from overseas, they detained the couple at a hotel for three days until nature took its course.

The evidence thus produced, authorities prosecuted. But, the High Court acquitted the couple on the ground that the evidence had been obtained while the couple were detained illegally.

That was early in 1984. The government promised to plug the legal loophole, and parliament has approved legislation permitting detention — on a judge's order — when concealment of hard drugs is suspected.

In the meantime, customs officers say eight suspected drug carriers have entered the country and avoided detention.

DEPARTMENTS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Mentors: The Power of Example

Number: 675.
Subject heading: Attitudes and values, lifestyle.
Details: 30 min, 16mm, color.
Synopsis: Popular television, sport, and rock personalities are interviewed about their lives. They tell how they have achieved success without using drugs, and stress that healthy lifestyles do not include the use of drugs. Viewers are urged to work hard and believe in themselves.
General evaluation: Fair to good (3.5). Although the interview format seemed long, the messages delivered by these celebrities were clear and could lead to discussion about healthy lifestyles. Public broadcast was recommended.
Recommended use: With a resource person, this film could benefit those 12 to 14 years of age.

Drug Information Series: Marijuana

Number: 686.
Subject heading: Cannabis.
Details: 10 min, color.
Synopsis: Two paramedics are concerned they are seeing an increase in people experiencing paranoid reactions to marijuana. One asks an instructor if there is any reason for this apparent change. Together, they review the potential health effects of cannabis use.
General evaluation: Poor to fair (2.5). The presentation of the information was unrealistic and, because of factual problems, this film was judged a poor teaching aid.
Recommended use: None.

The Physiological Effects of Cocaine

Number: 684.
Subject heading: Cocaine — drugs/pharmacology.
Details: 20 min, color.
Synopsis: Cocaine is becoming increasingly popular as a recreational drug. A pharmacologist gives an illustrated lecture on the historical and current use of this drug. He explains the physical symptoms and the hazards of using cocaine.
General evaluation: Fair to good (3.7). Although this film contained good information, the lecture method of presentation limits its effectiveness as a teaching aid.
Recommended use: This film could benefit those working in the health professions as a good overview of cocaine.

Drug Dependency: Early Warning Signs

Number: 685.
Subject heading: Drug use: etiology and epidemiology.
Details: 22 min, color.
Synopsis: Richard Crenna narrates this film dealing with 10 warning signs of possible drug abuse. Each warning sign is illustrated by a person using a different drug and experiencing problems. Anyone experiencing any of these warning signs is urged to seek professional help.
General evaluation: Fair (3.3). Some of the scenes portrayed were considered unrealistic. For example, daily use of LSD is extremely unusual.
Recommended use: With a resource person, this film could benefit general audiences.

New Books

by MARGY CHAN

Arrive Alive: How to Keep Drunk and Drugged Drivers Off the Road

. . . by Peggy Mann

Peggy Mann, author of *Marijuana Alert*, has once again written a very readable book — this one on the problems of drunk and drugged driving. Besides discussing the problems, the book covers a broad spectrum of programs and legislative approaches that are working well in some communities throughout the United States. This is an informative book for citizen activist groups, parents, teachers, and legislators. The appendix contains interesting bits and pieces of information, such as: statistics on traffic deaths, recipes for non-alcoholic drinks, and a resource list with annotations.

McGraw-Hill, New York, 1985. 497 p. $8.95 (paper). ISBN 0070399085

The Benzodiazepines: Current Standards for Medical Practice

. . . edited by D. E. Smith and D. R. Wesson

Intended for practising clinicians, this book covers therapeutic applications of benzodiazepines as well as their non-medical use, misuse, and abuse. The contributing authors also review the social and regulatory issues from an international perspective. The goal is "to codify current standards of medical practice utilizing benzodiazepines and to provide an index to clinically relevant literature developed through experience with benzodiazepines during the past 20 years." There is a useful appendix providing cross-reference of clinically-used benzodiazepines by research, generic, and trade names appearing in the medical literature.

MTP Press, Lancaster, 1985. 313 p. ISBN 0-85200-783-3

A deathly dance

LONDON — As the London Festival Ballet was giving a performance of "La Sylphide" here recently another dance — by doctors — was taking place outside. The doctors chose to perform the "Dance of Death" on the steps of the Royal Festival Hall as their protest against the ballet, sponsored by a tobacco company. *The Medical Post* says the ballet protest was organized by TREES — Those Resisting An Early End Through Smoking.

NEWS

Youth club objective is abstinence by all

MONCTON — French-speaking parents and kids here are joining a group which strives to promote abstinence from all drugs.

The project, under the auspices of the provincial Alcoholism and Drug Dependency Commission (ADDC) requires total commitment and involvement by young people and their parents, says Aline Comeau, a counsellor with the commission.

Known as *Club d'abstinence de la drogue, de l'alcool et de la cigarette*, or CADAC, it offers membership to youth between the ages of 12 and 16 years. Those who join promise verbally to abstain from alcohol, other drugs, and cigarettes for six months. Failure to comply can mean denial of social activities the group sponsors, Ms Comeau told **The Journal**.

After six months, members are required to sign a formal pledge to abstain.

Two CADAC functions are held each month. One meeting is formal and includes discussion of lifestyles, responsible decision-making, and personality development. The other function is social and designed to foster child-parent relationships in a fun setting that demonstrates that alcohol, other drugs, and cigarettes are not essential to having a good time.

Ms Comeau says the program leans heavily on self-encouragement and peer pressure among young people, coupled with participation by parents.

ADDC counsellor Jean-Guy LeBlanc told **The Journal** the young people are being given the tools for responsible decision-making. Whether they drink at an older and legal age is a matter of choice.

He stressed: "The project is not intended to function as a baby-sitting service. Parents are expected to attend the information meetings, to help organize special events, to participate in the social activities, and to provide other assistance such as transportation.

Ms Comeau cautioned that the program "is not designed for the serious delinquent or abuser, although if a person with serious problems wishes to join CADAC, this is possible."

At present, CADAC has three groups of about 45 members each in the eastern portion of New Brunswick. Planning for a September, 1986 English-speaking group is underway.

Drink sales slump reflects cautious consumer mood

FREDERICTON — A definite trend to lower consumption of spirits continued in New Brunswick in fiscal 1984/85.

The annual report of the New Brunswick Liquor Corporation says the decline of 5.7% "is a result of changing customer attitudes, lifestyle changes, and a cautious consumer mood."

While per capita consumption of spirits has fallen to 4.87 litres from 5.17 litres in 1983/84, and 5.81 litres in 1982/83, beer and wine have gained in favor.

Wine, which two years ago gained 15% in sales volume, increased a further 5% in the last fiscal year, to 4.49 litres per capita — close to spirits consumption. Beer sales, which had been slipping, bounced back to 72.87 litres from 72.06 litres.

Beer sales contributed 57.2% of the gross income of the liquor corporation, an increase of 4.57%. Spirits sales were down 6.4%, accounting for 33.6% of the total, while wine — perhaps reflecting currency changes — accounted for 9.2%, down from 9.4%, despite increased consumption.

Rising prices narrowed the gap between reduced sales of liquor and the dollar revenues realized. The corporation had a record gross income of $191,727,168 from a population of approximately 700,000. Spirits revenues were down only $1,346,362 for a total of $64,492,557. Wine revenues were $17,587,244 — up from $17,128,585.

Beer revenues showed the biggest dollar gain, increasing to $109,647,367 from $100,194,126 in the previous year. Rising prices accounted for a dollar gain of 9.43% on a consumption increase of only 1.35%.

Tax and other increases imposed since the end of 1984/85 pushed prices higher than ever in 1985. Last summer, segments of the hospitality industry voiced concern that high beverage alcohol prices, combined with gas, accommodation, food, and entertainment cost increases deter tourists, especially from the United States.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subecription Retes:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year

Bulk Subscription Retes:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

Heather Graham

'Cigarette companies are pretty evil'

Tobacco mystique wilts under kids' scrutiny

By Katherine Lake

WASHINGTON — A group of California researchers is using a different approach to cigarette smoking prevention for children.

Instead of using the traditional "scare tactic" method by concentrating on smoking's health hazards, Stanton Glantz, MD, and colleagues are exposing the deceptive advertising practices of the tobacco industry — and its efforts to attract children to smoking.

At the annual meeting here of the American Heart Association, Dr Glantz said children in grades six to nine — the years during which they are at great risk of starting to smoke — do not believe they will suffer any long-term consequences from tobacco use. The spectre of future disease is too remote a possibility to have immediate impact.

But, studies at the Berkeley Hall of Science, Berkeley, California show children to be preoccupied with independence issues at this age. They also have a fear of addiction. As a result, a combination of these two concerns can add up to a powerful anti-smoking recipe.

"We tried to build into our curriculum the argument that if you smoke cigarettes, you get addicted and end up giving away your independence to the cigarette companies, who are pretty evil people," said Dr Glantz, associate professor of medicine, University of California, San Francisco.

"We included the fact the cigarette industry specifically concentrates on ways to get children addicted because the manufacturers' main concern is getting the price of a pack of cigarettes from them every day of their lives."

This was done by letting the children study excerpts from the 1981 (United States) *Federal Trade Commission Report on Advertising* that shows tobacco companies have secret policies to try to attract children to smoking.

In addition to issues of autonomy, the curriculum includes other elements that have special appeal to kids — cowboys, villains, no preaching, and independent research.

Participants in the program draw their own conclusions after completing a five-part curriculum. Each segment takes about 30 minutes of classroom time. During the course, students interview a long-term smoker, build a simple smoke-trapping machine, learn facts about cigarettes and smoking, and study both advertisements and advertising practices.

The crowning touch is a documentary film, *Death in the West*. So powerful is this film that it was suppressed by a court order requested by Philip Morris, manufacturers of Marlboro cigarettes, after it was first shown on British television in 1976.

"This approach made a real impression because our study results showed the credibility of the industry really suffered after kids went through the curriculum and saw the film. The blush on the Marlboro cowboy is really taken off by the film," Dr Glantz said.

The film contrasts the free-wheeling image of the famous Marlboro cowboy with the reality of six, real-life US cowboys who are dying of heart disease, lung cancer, and emphysema as a result of lifetime smoking (**The Journal**, December, 1976).

"But, the real stars of the film are two senior executives from Philip Morris who persist in claiming that no conclusive evidence exists that cigarette smoking is dangerous to people's health," Dr Glantz said.

He added that the film's deglamorization of the Marlboro Man is especially important: "Philip Morris is the leading purveyor of cigarettes to sixth graders.

"Of the kids who smoke, the overwhelming bulk smoke Marlboros. There's a lot of talk about Virginia Slims (another brand of cigarettes), but girls smoke Marlboros just as much as boys."

After obtaining a bootleg copy of the film in 1983, Dr Glantz and colleagues persuaded the San Francisco affiliate of the US National Broadcasting Corporation to televise the documentary. Two weeks before the film was shown, 90,000 children in northern California completed the curriculum. From this large pool of children, Dr Glantz and colleagues randomly selected 335 sixth graders to serve as a study group. A control group was made up of 248 grade six students who neither completed the curriculum nor saw the film.

All children in the study completed a questionnaire concerning their knowledge of and attitudes to smoking. Children in the study group completed the questionnaire twice — before starting the curriculum, and after completing it and viewing the film.

The post-curriculum questionnaire was identical, except for a segment on *Death in the West*. The control group completed the same questionnaire — except for the section dealing with the film — and at the same times as the study group.

While attitudes appeared to change markedly in the study group, the same was not true in the control group. The responses of the control group were similar to those of the children in the study group before taking the course and viewing the film.

As well as being more knowledgeable about the effects of cigarettes and cigarette smoke, the study group had a far more negative impression of the Marlboro Man and Philip Morris.

After the course and film, most study group children perceived the legendary cowboy to be less brave, less smart, less tough, less in control of himself, and less happy. They also believed the manufacturers of Marlboro cigarettes to be less honest, more eager to suppress information on the dangers of smoking, and more interested in luring children and young people into smoking. The majority expressed the belief that no company has the right to suppress from the public any film that portrays their product in a negative way.

Dr Glantz and colleagues plan to follow the children in the study to determine whether the curriculum and film will affect their attitudes in the long run and actually deter the majority from smoking. He said the curriculum has the potential to make a major impact in the future. So far, 300,000 US grade schoolers have completed the course and seen *Death in the West*.

THE BACK PAGE

Sexual problems after sobriety — page 12

Responsible beverage service: some of the issues — pages 9/10

Women and cocaine — page 3

Vol. 15 No. 2 2nd Class Mail Reg No. 2776 TORONTO, February 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Response is chaotic to multinational criminals

Coordinated anti-drug action is imperative

By Anne MacLennan

TORONTO — The unrelenting expansion of illicit drug production and trafficking, and the alarming potential in synthetic drugs, makes coordinated counteraction imperative, nationally and internationally.

"Without it, we haven't got a hope," says H. David Archibald. "At best, successes will be isolated and temporary.

"Drug traffickers are multinational corporations with highly-developed systems — marketing specialists, promotion specialists, training of couriers.

"They have it in their power to change the political map of the world," Mr Archibald, president of the International Council on Alcohol and Addictions, and a long-time consultant on drug issues to the United Nations and the World Health Organization, told **The Journal.**

In contrast, he says, the addictions field is rife with territorialism and mutual disdain, specialty for specialty, group for group.

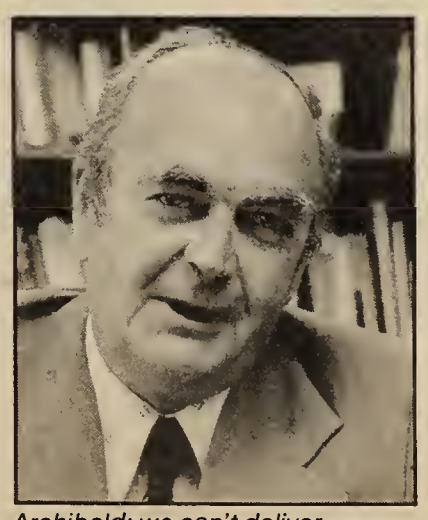
"The people who are attempting to do something constructive, those who work on the so-called reduction of demand, are disorganized among themselves.

"Researchers can't communicate with treatment workers, physicians can't communicate with educators, and so on.

"At the same time, people in research, treatment, and prevention tend to look down on the police. And vice versa.

"If we can't get together and develop a comprehensive approach, a coordinated approach, this problem will only get worse — except in pockets and temporarily."

Mr Archibald was responding to two reports released in January — one by the Royal Canadian Mounted Police (RCMP) [see story below], and one by the UN International Narcotics Control Board (INCB).



Archibald: we can't deliver

Both reflect the remarkable and continuing success of illicit drug producers and traffickers in the face of almost-universally strengthened police measures.

Mr Archibald: "For a very long time, officials, including Canadians, believed the drug problem could be removed by law enforcement alone — reducing the supply of drugs and cutting down trafficking.

"It didn't work.

"Then, everyone began looking to demand reduction, and the pendulum started swinging in the other direction.

"The problem is, we on the demand side are in a chaotic situation. We just can't deliver. There's not a hope on our own. And now, the pendulum is swinging back.

"But research, treatment, and education are important and must be inter-related to provide a comprehensive approach to be coordinated with enforcement efforts.

"For this, we need communication, conversation, and increased understanding of the potential contribution each can make to the total system, rather than the mutual disdain that exists now within groups and across boundaries."

In their reports, both the RCMP

(See Drugs, p2)

Profits must be taken from illicit drug trade

By Joan Hollobon

OTTAWA — Illicit drug trade profits should be seized to help defray crime-fighting costs, says Canadian Solicitor General Perrin Beatty.

In releasing the Royal Canadian Mounted Police's (RCMP) *1984/85 National Drug Intelligence Estimate (NDIE)*, the solicitor general said the only way to combat illicit drug trafficking is to reduce the profit motive. But, effective enforcement in this area requires improvement in the laws governing seizure and forfeiture of the proceeds of crime.

"I should like to see these funds turned over to help defray the enormous costs that taxpayers are constantly having to assume to investigate, arrest, and convict criminals in the drug trade," he said.

Legislation, enforcement, and "the active cooperation of the financial and business communities both in Canada and abroad" will be needed to ensure that convicted criminals do not profit from their crimes, the solicitor general said.

One major representative of the financial community entered the fray early in the New Year. Royal Bank chairman Rowland Frazee told shareholders the bank is taking steps to avoid being used by criminals to launder money derived from criminal activities, particularly the illicit drug trade.

Drugs international — p16

Peter Engstad, director of law enforcement policy, the solicitor general's department, told **The Journal** there are "a number of shortcomings" in the existing law.

For example, it is an offence under section 312 of the Criminal Code of Canada to possess the proceeds of crime. However, if the proceeds have been invested in real estate or deposited on account in a bank, they cannot be seized under current search and seizure legislation, Mr Engstad said.

Another area to be looked into is the section in the Criminal Code dealing with forfeiture, which is unclear. Because of this, the section remained unused until recent attempts to use it "to find out with greater precision its strengths and weaknesses."

The RCMP began its Anti-Drug

(See Illicit, p2)

Older alcoholics: the file builds

By Joan Hollobon

TORONTO — A pioneer program for older alcoholics begun here two years ago promises to be the wave of the future as the proportion of the elderly in the Canadian population increases.

The Community Older Persons Alcohol (COPA) project may also hold lessons for the treatment of younger people with alcohol or other drug problems.

Key elements in helping older alcoholics differentiate the strategy from traditional alcohol treatment programs, which require the individual to admit a problem, to desire a change in lifestyle, and to become abstinent.

"Alcoholism" and "alcoholic" are taboo words in helping older people. Treatment involves working with people who more often than not deny they have a problem and show little desire to change their lifestyle or to stop drinking. As well, many are seriously ill, socially isolated, and may have housing or other problems of daily living.

"If you can't address these problems, the person is not going to listen to counselling on alcoholism," Sarah J. Saunders, MD, director of COPA and a physician in the Community Hospital Outreach Service of Ontario's Addiction Research Foundation (ARF) here, told **The Journal.**

Gilbert on drugs, aging — p5

COPA helps older people in their own homes. It grew from an institutional program begun in 1973 in response to a plea from the harried administrator of a Toronto home for the aged, who was faced with disruptive behavior by alcoholic residents.

A study of alcoholics in the institution showed all were severely isolated from other residents and had no interests apart from drinking. They got drunk several times a week and, when intoxicated, became verbally or physically violent. They communicated poorly and either denied their drinking problems or were unwilling to change their drinking patterns (**The Journal**, October, 1982).

A 1981 comparison of the residents' behavior in the first three months and in a three-month period after a year on the COPA program provided striking results: drinking episodes were reduced to 498 from 843; episodes of intoxication to 32 from 257; and episodes of physical or verbal abuse to two from 72.

Back in 1973, the literature taught that older people do not have drinking problems and that controlled drinking was an impossible goal. A literature search revealed nothing whatever about alcoholics in homes for the aged.

Even now, little is known about the older alcoholic, including the prevalence of alcoholism within this population. It is believed that from two percent to 10% of people older than 60 years have a drinking problem. The figures increase to between six percent and 20% for those living in institutions.

Many in the treatment field remain unconvinced of the need for

(See COPA, p2)

INSIDE

NEWS

Briefly ...

Sloppy seizure

TORONTO — Two men who swallowed condoms filled with hashish oil have been acquitted in Provincial Court here because a judge decided police used unreasonable search and seizure methods. The suspects had been arrested and forced to consume a laxative at a local hospital until the evidence emerged, says *The Toronto Star*.

Pub treatment

LONDON — Doctors at a loss about what to do with alcoholic patients may soon be prescribing trips to a local pub. The Milestone — Britain's first and only alcohol-free pub — could become the first stop for many drinkers. Based in Exeter, the pub serves only fruit juices and non-alcoholic beers and wines, says *Doctor*. An Exeter doctor sees the pub attracting the young. "It could be the start of a national trend," said Dr Roger Stephenson.

A deathly trip

NANAIMO, BC — New Year's Eve party revellers here were able to get a free ride home compliments of a local funeral home. Those who had imbibed too much in the way of holiday spirits could be chauffeured via hearse if they were unable to catch a cab, says *The Toronto Star*.

Airborne fisticuffs

LONDON — A United States psychologist was charged with assault following a mid-flight row about cigar smoking which diverted a New York-bound jumbo jet, says *Reuter*. The psychologist was physically objecting to another passenger's demand that he butt out while seated in a no-smoking section.

A riot act

LONDON — Riots last year in the English city of Birmingham — which left two dead and dozens of stores gutted — were organized by drug dealers and addicts, says an official police inquiry. The report quoted in *The Toronto Star* says the rioting was orchestrated "by local drug dealers who had become fearful for the demise of their livelihoods."

Legionnaire's risk

LONDON — Smokers now face the added health risk of contracting Legionnaire's disease, the House of Commons here has been told, says a report in *Doctor*. Junior Health Minister John Patten says the department of health and social security has some evidence smoking can give rise to an increased possibility of developing the disease "after exposure to infection through inhalation of polluted water droplets."

Have a heart

CLEVELAND — A doctor who has visited the Soviet Union says better artificial hearts will be made there following Soviet leader Mikhail Gorbachev's crackdown on workplace drinking. The connection? Dr Yuhiko Nosé said at the meeting here of the International Society of Artificial Organs that the clean-up means medical laboratory staff "don't drink, so they have to work."

Drugs-terrorism link a major issue

(from page 1)

and the INCB touch on the unprecedented power accruing — with the profits — to the drug criminals, and the increasing use of the profits either to diversify into, or to assist criminal associates in a range of activities, including illegal traffic in firearms, subversion, and international terrorism.

So-called narco-terrorism is an "ominous development," says the INCB, the agency which oversees the implementation and administration of the UN drug treaties around the world.

Mr Archibald: "Narco-terrorism is a very important issue — very important. And I think people have to be aware of it — at all levels.

"The massive amounts of money in illicit drug trade are the financial engine that drives international terrorism, political instability, and illegal trade in firearms. The bottom line is that national security is becoming a very major issue in a number of countries."

Mr Archibald, when he was Royal Commissioner into the Use and Misuse of Illicit Drugs and Alcohol in Bermuda, studied, in the process, a wide range of classified documents from many countries. He adds: "Already-unstable countries in Latin America are more and more weakened by drug-related crime.

"When the foreign income from drugs, in US dollars, in countries such as Peru, Bolivia, and Colombia becomes a significant part of their foreign exchange, then those countries become economically dependent on that income.

"For many of the countries involved, it becomes a *Catch*-22 situation. Mexico is increasingly coming under the influence. The corruption that has developed in a number of countries in the Caribbean is a direct consequence of drug traffic."

Illicit drugs business in Canada hits $10 billion: RCMP

(from page 1)

Profiteering Program in 1981 (The Journal, March, 1982). Despite potential problems with section 312, several convictions have been obtained.

Protection of the victims of crime is also a concern of the solicitor general, Mr Engstad said.

"The idea is to look at a variety of ways of separating the bad guys from their ill-gotten gains and to have a procedure in place that protects third party interests," he said.

Once again, the *NDIE* reported a rise in the amount of illicit drugs entering Canada.

The RCMP's Drug Enforcement Directorate headed by Chief Superintendent Rodney Stamler first published the estimate in 1983 for the years 1981-82.

That year, *NDIE* estimated that illegal drugs generated $8 billion in retail sales. This year, the estimate is $10 billion. The estimate is based on the amount of drugs seized and the premise that this probably represents only about 10% of the drugs actually in circulation.

This approach has long been questioned throughout the international community and by the police themselves, but remains in use in the absence of factual information unobtainable in clandestine situations.

Heroin and cocaine imports to Canada have almost tripled since 1980, the *NDIE* reports.

In 1984, the RCMP and Canada Customs seized 40 kilograms of heroin compared to seven kg in 1980. Comparable cocaine figures were 115 kg in 1984 and 43 kg in 1980.

Cannabis seized (including cannabis derivatives) was dramatically reduced to six kg in 1984 from 46 kg in 1980.

The report notes the many international ramifications that affect drug control in Canada. For example, many countries do not consider possession of the proceeds of drug trafficking a crime as long as the offence occurs outside their territories. Changing trafficking patterns also affect Canada.

But 'need for treatment is growing'

COPA fights 'why bother' attitude

(from page 1)

services for the elderly. But, Dr Saunders has found a large and growing need, and she has proved many older people can reduce their drinking sufficiently to resolve attendant problems.

Dr Saunders established COPA in 1983 with the support of others, particularly the ARF, Blossom Wigdor, PhD, head of the gerontology program at the University of Toronto, and Thomas J. McCann, MD, vice-president, medical affairs (medical director), Queen Elizabeth Hospital, a chronic-care hospital here. Dr McCann is also head of the hospital's chronic care services and day hospital program.

Saunders: new tools

As a three-year pilot project, COPA receives an Ontario Ministry of Health grant up to $75,000 per year. Office space and equipment are provided by the Queen Elizabeth Hospital, for one dollar a year.

The experience gained in the earlier institutional experiment was essential to COPA's success. So little was known about working with older people that the program had to devise its own 'tools' — new definitions, admission criteria, method of operation, and assessment forms.

COPA includes people 55 years old, but will sometimes accept younger people who have health or other problems characteristic of the older group.

It also still fights the "Why bother?" attitude: "They're old, they'll die soon," "You can't teach an old dog new tricks," or "Why take away their sole remaining pleasure in life?"

Dr Saunders takes the last attitude seriously. The core of the COPA program is to improve the client's lifestyle and happiness: alcohol is no longer a pleasure when it creates increasing isolation, depression, or physical sickness.

Evaluation criteria for a program such as COPA must also differ from the traditional criteria.

In an address to a seminar on alcohol and the elderly held last fall by the ARF's School for Addiction Studies, Dr Saunders described a client "who, in a traditional program, would look as if he had gotten worse."

This man was living in a "terrible rooming house situation." He was extremely ill and malnourished, existing on three meals a week from Meals on Wheels. Totally isolated, he sat on his bed all day looking into space. But, he was totally abstinent.

Today, he lives in his own apartment, is well medically, eats well, and goes out to visit friends. But, he drinks two or three bottles of beer a day.

"Does that mean this person is a treatment failure?" Dr Saunders asked.

Tiina Corbit, PhD, training officer at the School for Addiction Studies who arranged the seminar for ARF scientists, said it was the first time alcohol and older people had been the chosen topic.

She said the new focus is partly because of the increasing number of older people in the population, but also because evidence is emerging to disprove the idea that alcoholics "mature out" as they age.

As well as the survivors of the early onset drinking, late onset problem drinkers are coming to the fore — abstainers or moderate drinkers who increase their intake often in response to the isolation resulting from the loss of "important links in their lives."

Dr Saunders suggests that techniques developed to work with older people who refuse to acknowledge alcoholism may be adaptable to younger alcoholics, allowing for earlier and briefer interventions.

The only other similar project in Canada known to her is Lifestyle Enrichment for Senior Adults (LESA) in Ottawa.

— coming up in —

THE JOURNAL

- Urine screening — some of the issues

Oppenheimer: involvement

DND chief will guide 1987 meet

VIENNA — Tamar Oppenheimer, director of the United Nations Division of Narcotic Drugs, Vienna, has been appointed secretary-general of the international, ministerial-level conference on drug abuse called for 1987.

In a major new thrust in international control efforts in June, 1985, UN Secretary General Javier Perez de Cuellar called for the conference for countries around the world to show their commitment — at senior levels of government — to reducing drug abuse and trafficking (The Journal, July, 1985).

Mrs Oppenheimer, a Canadian and a gradnate of McGill University, Montreal, was appointed director of the division in April, 1982.

Solicitor General Perrin Beatty, in releasing the RCMP 1984/85 National Drug Intelligence Estimate, said Mrs Oppenheimer's appointment is "indicative of Canada's involvement and influence in the international war against drug abuse."

NEWS

They're 'bombarded' with the drug by men

Women's cocaine use is probably underestimated

By Harvey McConnell

NEW YORK — There are far more women with cocaine problems in the United States than surveys indicate, because a "double standard" inhibits them from seeking treatment.

And, when they do seek help, many will also need treatment for secondary addictions to excitement and to sex, says Nanette Stone.

For more than a decade, Ms Stone has counselled addicts here and, with her husband, Arnold Washton, PhD, and New York City Medical College, started a metropolitan cocaine hotline which was the predecessor to the US 800-CO-CAINE hotline (**The Journal**, October, 1985).

Ms Stone told a national cocaine conference here that married men come into treatment mainly because they want to save their jobs and keep their wives happy.

Women, on the other hand, enter treatment because they know they're out of control with cocaine, or any drug, and fear reprisals, judgements, and perhaps abandonment by their families.

Ms Stone and her colleagues have found families of women addicted to cocaine are confused and angry. Because of the roles women play as wives and mothers, most families cannot accept the situation.

"The whole family needs to learn how to turn around and support the mother," she added.

Ms Stone said changed patterns in telephone calls to the national hotline in the past two years show the number of women with cocaine problems is probably underestimated. In 1983, one-third of all calls were from women; by the end of 1985, this had grown to slightly more than 50%.

"However, I think the most disturbing information we have to date is that about 20% of high school students had used cocaine in the past six months or so, and that the girls are neck-and-neck with the boys.

"Women have always been behind men in illicit drug abuse, but boys and girls are about even in beginning to use cocaine."

She said women in much greater numbers are now being encouraged to use cocaine: the price has dropped and women can now afford to buy it; women in the work force are exposed to other people using drugs; and, cocaine is like a contagious disease — there is enormous social pressure to use it.

"Women entering high-income and high-pressure jobs have found that high stress coupled with a drug that instantaneously removes fatigue and bolsters confidence is a dangerous combination."

On the other hand, women who have little or no regular income find that dealing in cocaine is a route to easy money and new financial independence.

"What we are hearing from a lot of women is that the high risk, the easy money, and the physical danger that come along with dealing in cocaine are exciting in themselves. They find their lives rather boring and empty compared with this highly-charged kind of experience."

About one-third of the women who use cocaine heavily also deal. These women need treatment for a secondary condition. "They are excitement junkies," Ms Stone said.

Much effort is needed to find other ways to help give them pleasure.

This can range from taking up sky diving, to hot air ballooning over New Jersey, to getting an excitement kick by appearing with Ms Stone or other professionals on television talk shows or in lectures.

As for cocaine and sex, the drug's use is now so rampant in the singles scene that even women not motivated to look for cocaine are continually bombarded by men trying to give the drug to them.

The men, when questioned, say they feel more competent in dealing with possible rejection from an attractive woman if they can offer her cocaine.

Ms Stone: "We have found that about 85% of women have been introduced to cocaine in a romantic kind of situation or as sexual barter, and about 65% maintained their habits without ever having to buy it."

Sexual acting-out behavior must be dealt with, she added.

"Help the woman find other ways of pleasing herself sexually and finding other kinds of social outlets." But, "it is mostly a no-win situation.

Stone: doing the diapers on coke

Sexual barter: 65% of women never have to buy their own supply

"I think, again, there is a secondary addiction, and that is addiction to men. It has to be treated up front."

Many housewives are resentful of their position and want to find ways they think will put them on the cutting edge of society.

"We have a contingent of women who were meeting in the laundry room of an apartment building doing towels and diapers while snorting cocaine," Ms Stone said.

"It gave them the feeling they were doing something chic, something that was *avant garde*."

About 50% of the women who call the hotline, ostensibly about their husbands' use of cocaine, are themselves addicted to the drug.

As for cocaine and pregnancy, Ms Stone said studies show the fetus is severely affected by the drug during the early months of gestation. At the same time, women who use cocaine heavily often miss menstrual cycles, but this does not mean they cannot become pregnant.

Many women using cocaine do not even know they are pregnant. Or — and Ms Stone says this is an excellent example of how great the denial is with cocaine — they know they are pregnant but continue to use the drug because they mistakenly believe "it only lasts 20 minutes and gets out of their system quickly."

Women who give up cocaine during pregnancy become more agitated as birth nears: they feel their body is not their own and they long for the drug. And, the stress of a new infant in the home finds many women resuming their cocaine use.

Ms Stone: "We see women rotating their breast-feeding schedule around their cocaine use. It is not uncommon for women to pump out the breast milk after they have taken cocaine thinking that the cocaine goes through the body that quickly."

Ms Stone concludes that treatment professionals can be as guilty of double standards as family members; many consider women who use drugs more deviant or more psychologically disturbed than their male counterparts.

"Women are exquisitely sensitive to this judgement," and treatment professionals must strive to rid themselves of such biases if they hope to keep women in treatment.

INSIDE OUT

Why cocaine? Why now?

I can gratefully say, as far as cocaine is concerned: it's not for me.

The effects of the big drug of the 80s are sometimes too eerily close to the jangly jitters that amphetamines provide, I've been told. And, since the only time I tried speed was so terrifying I vowed later never again to be that stupid, I have been spared more or less permanently another addictive option.

It's not that I haven't given the real thing a shot or two.

Who, indeed, has not, at least if you're somewhat upwardly mobile, more narcissistic than the societal norm, and have a few spare gold coins jingling around in your designer jeans? One must strain these days to keep up with the flow.

So, I've partaken.

Unsatisfactorily so, let it be said. Like many drop-dead downtowners, I found the stuff I sniffed a few times to be somewhat of a bust, about as interesting and deep as an *Entertainment Tonight* episode.

I was later told — by more "sophisticated" types, naturally — that what I had had was not the real high-octane fuel, etc, etc. But, I'd already made up my mind to give it a permanent farewell.

Thus, in my passive role as a relatively neutral observer of the burgeoning phenomenon, it has intrigued me to try to understand what the fuss is about.

Now, I know cocaine does get the job done, as it were. I have seen its cumulative effects on a few people (none of whom are in my business), and their "progressive education" hasn't been pretty to view.

Strangely, the first time I became aware of the drug was about 18 years ago (talk about being trendy) when a truck driver — yes, one of those God-fearing, hard-working, salt-of-the-soil sods — called me up about 3 am.

He worked for me part-time then, when I was managing a take-out restaurant, and that night, after I picked up the phone and listened to him, I became truly alarmed. And confused.

The first time I became aware of the drug was about 18 years ago

The man usually made sense; he was an intelligent person.

But that early-morning raving rap he was orchestrating for my benefit — it went on and on and on — was frightening.

He sounded insane, deranged, and I thought I should probably contact his wife.

The next day, he informed me he used cocaine frequently (would I like some?), thought it gave him power, more control — the usual qualities drugs allegedly provide.

I never heard from the guy again. Years passed, and then coke came roaring back into the collective consciousness.

It's not necessary to repeat today's cocaine statistics here. You know them. I know them. And they're changing all the time, anyway.

But, they are truly scary. Yet, I'm completely certain, even with my limited knowledge, that cocaine is one "lifestyle" that hasn't begun to peak yet.

What the hell is the big deal now about coke? Why the stampede today — why not back in the 60s, when there was more money spread around, from top to bottom, and people were willing to give just about anything a go?

Why has it seemingly been waiting in the shadows, ready to make a splashy bow now?

I think there are a few reasons, none of them "scientifically" based, of course; I believe that squeaky clean Ronald Reagan (oh, irony of ironies) and the economic *laissez-faire* style he's been setting has more than a little to do with the upsurge.

So, humbly, here are some of the reasons, as I see them:

- We're in the midst of a quick-fix economy. The notions of being patient, working hard, being loyal, and feeling as if you have a clear, long-term stake in a company are now taking a tremendous battering. There's no grounded sense of a future, the society's job patterns are shifting rapidly, and the goal is to make a fast kill, in the market, wherever — get in, get out, and yank yourself out of the struggle.
- MBAs (so-called masters of business administration) are taught to focus only on quarterly earnings; they can shift their allegiances at will, and the products they sell — as they are themselves — are interchangeable.
- Cocaine dovetails perfectly with this mindset, because it gives you the illusion of clear-mindedness, manipulative power over people, control of yourself, and an awesome loathing for any kind of business idealism. There is nothing emotionally sloppy about cocaine: it offers a spurious sense of invulnerablility that meshes with the business world's rollercoaster coldness. It's no wonder so many pimps are into the drug; it's great for business.
- The emotional distance cocaine engenders is also useful in sex and relationships; it helps to cut down on time "wasted" getting to know one another. Indeed, one of cocaine's greatest seductive powers is that it shields a person from emotional involvement with another person who may hurt him by exposing his weaknesses. Cocaine makes both parties commodities — and that suits the times just dandy. (The fact the result of too much coke can be emotional breakdown is usually conveniently ignored; heavy coke users don't possess any strong pipeline to the future.)
- The drug's popularity is also helped by the Yuppie ethic. It costs a lot and is therefore elitist; it isn't like marijuana, which anyone can buy and anyone can use and which is therefore socially inferior.

When you use coke, you're making a fashion statement.

Nobody ever said that about heroin.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Pot-using pilots off mark 24 hours later

Marijuana can seriously impair the flying ability of pilots even 24 hours after their use of the drug. That's the conclusion of Californian researchers who tested the abilities of eight experienced, private pilots on a flight simulator one day after smoking a marijuana cigarette containing 19 milligrams of delta-nine-tetrahydrocannabinol (THC). The pilots, all experienced marijuana smokers, received eight hours training on the flight simulator prior to smoking what was described as a "strong, social dose" of the drug. Their performance on the simple landing procedures was impaired significantly one and four hours after receiving THC. Even one day later, their mean performance showed a trend toward impaired overall performance. Certain components of the landing task, for example the "number and size of aileron changes, size of elevator changes, distance off-centre on landing, and vertical and lateral deviation on approach to landing" were still affected significantly 24 hours after drug intake, although the pilots reported no awareness of impaired performance. The researchers, from the Palo Alto Veterans Administration Center, Stanford University School of Medicine, and Naval Air Station at Moffitt Field, said the results of their study suggest a need for concern about "the performance of those entrusted with complex behavior and cognitive skills within 24 hours after smoking marijuana."
American Journal of Psychiatry, Nov, 1985, v.142:1325-1329.

Untreated addicts 'not uncomfortable'

Similarities were more striking than differences when treatment-seeking opiate addicts were compared with untreated addicts in a New Haven, Connecticut study. Bruce Rounsaville, MD, and Herbert Kleber, MD, department of psychiatry, Yale University School of Medicine, compared the characteristics of 204 consecutive opiate addicts seeking treatment, with 105 addicts who had not sought treatment within the past three years and who were identified through a chain-referral technique. The researchers found no significant differences in the indices of current and lifetime opiate use between the two groups in: current engagement in risky, illegal activities connected with the procurement of drugs, psychiatric disorders other than depression, and occupational functioning. Those addicts who had not sought treatment were found, however, to have more adequate social functioning, fewer drug-related legal problems, and lower rates of depressive disorders. While noting their sample of untreated addicts is not necessarily representative, the researchers conclude motivation appears to be the main reason the untreated group had not sought treatment "as many describe themselves as not especially uncomfortable with their drug use." They say the untreated group must still be viewed as a population at risk.
Archives of General Psychiatry, Nov, 1985, v.42:1072-1077.

Smokers and sore feet

"Smokers foot" might be an appropriate name for a chronic condition known as palmoplantar pustulosis, characterized by yellow pustules on the feet that fade into brown spots. Because a pilot study suggests a relationship between this condition and cigarette smoking, researchers Conor J. O'Doherty and Cecilia MacIntyre of the University of Edinburgh, Scotland, did a retrospective case-control study in five departments of dermatology in Great Britain. Patients presenting with palmoplantar pustulosis since 1980 (a total of 216) were matched with 626 controls who had other skin diseases, and were of similar age, sex, and date of presentation. For study purposes, smokers were defined as patients who had smoked at least one cigarette or small cigar a day or one ounce of pipe tobacco a month, for more than a year, and were smoking at the time of onset of the disease. Questionnaire answers revealed 80% of patients with palmoplantar pustulosis were smokers at the time of onset of the disease, compared with 36% of controls. The researchers calculate the relative risk of palmoplantar pustulosis occurring in smokers as compared with non-smokers is 7:2. But, they point out the reason for the association is not clear and that stopping smoking does not appear to lead to a permanent cure of the disease.
British Medical Journal, Sept, 1985, v.291:861-864.

Acetaminophen and hepatic/renal problems

Acetaminophen (eg Tylenol) should be considered as a possible culprit when an alcoholic presents with combined hepatic and renal insufficiency. That's the message from a group of San Francisco physicians who reported on five alcoholic patients developing cellular damage in the liver combined with renal tubular necrosis after taking acetaminophen for therapeutic reasons. Two of the patients died after admission to hospital. The researchers say all five patients had measurable concentrations of acetaminophen in plasma although measurement of this substance had only been requested on admission with two of them. Certain characteristics of these patients on admission to hospital distinguish them from those who present with alcoholic hepatitis and should alert physicians to the possibility of acetaminophen being a causative agent. The researchers say they reported the cases because of the high mortality rate and the initial misdiagnosis of the intoxication — one patient was actually treated with more acetaminophen after admission to hospital. They say while it's been known for some time that therapeutic doses of the drug can damage the liver of alcoholics, it was not widely appreciated that acetaminophen can also have toxic effects on the kidney.
Archives of Internal Medicine, Nov, 1985, v.145:2019-2023.

Pat Rich

Coke tied to cardiac trouble

By Katherine Lake

WASHINGTON — Snorting cocaine may cause heart attack and sudden cardiac death in young people with normal, healthy hearts, says a Boston pathologist.

Jeffrey Isner, MD, told the annual meeting here of the American Heart Association that snorting a dose of one gram can cause potentially fatal cardiac complications.

"This is not a large dose for a habitual user," the associate professor of medicine and pathology at Tufts New England Medical Center, told **The Journal**. "It's quite common for users to snort a gram spread out over several hours."

Six young men and one woman Dr Isner saw recently began to have heart problems one to five hours after an average intra-nasal cocaine dose of one gram. They ranged in age from 20 to 37 years. Six admitted to being frequent cocaine users.

Two of the men died suddenly as a result of cardiac complications — one from a heart attack and the other from a grossly abnormal heart rhythm. No evidence of heart disease was found in either of them during autopsy.

"Because of the close, temporal relationship between snorting cocaine and the onset of cardiac complications, we have to assume that the two are directly related, especially in the absence of any evidence of coronary artery disease."

Three of Dr Isner's surviving patients had heart attacks, one had a serious rhythm abnormality, and one had an inflammation of the heart muscle. Coronary artery X-rays did not show any signs of heart disease in any of these individuals.

Dr Isner said it is very rare for young people to have a heart attack or sudden cardiac death without heart disease or a congenital heart defect. Exactly how cocaine triggers heart problems in people with normal hearts is not known but is a topic Dr Isner intends to study in animals. He also plans to study effects on the cardiovascular system of various substances commonly mixed with pure cocaine before it is sold on the street.

Although he has seen a small patient sample, Dr Isner believes "the phenomenon is widespread."

He added that the association between serious heart problems and cocaine use was not made before because physicians have been unaware of it.

"Sudden death after cocaine use is almost always attributed to central nervous system or respiratory depression and these deaths are almost always the result of very large doses."

Edinburgh reports on IV drug users

Britain ups its spending on AIDS

By Alan Massam

LONDON — The British government has boosted dramatically — to £8.3 million (Cdn$16.9 million) — the resources aimed at checking the spread of acquired immune deficiency syndrome (AIDS).

This is in the face of growing evidence the disease will not remain confined to so-called "high-risk" groups, like male homosexuals and hemophiliacs.

Of particular concern to experts here is a report from Edinburgh. Family doctor Roy Robertson has found that more than 50% of intravenous drug abusers in some parts of the city show evidence of exposure to the virus.

IV drug abusers spread AIDS by sharing the hypodermic needles they need for their fixes (**The Journal**, October, 1985). But, because some of them are also prostitutes, there is little doubt they represent a route by which the disease can be spread to heterosexuals.

Until now, government health officials have discounted this possibility, because early studies suggested AIDS exposure was only occurring in between 1% and 2% of British IV drug abusers.

If the level of exposure currently being seen in Scotland spreads widely among drug abusers in Britain — as experience in the United States suggests it will — the AIDS epidemic here will take on an even more ominous character.

Officials of the Standing Conference on Drug Abuse are calling for immediate government intervention. They want a crash program to educate addicts about the dangers of sharing needles and also wider powers for doctors to prescribe "class A" drugs, notably oral methadone, to treat addicts and so discourage them from injecting.

The government's strategy for dealing with drug abuse certainly appears to be less successful than anyone would hope.

In fact, Martin Plant, PhD, senior research fellow at the department of psychiatry, University of Edinburgh, believes that sometimes the effect of health education is actually to encourage drug abuse.

Dr Plant, has been following the progress of 1,036 Scottish youngsters from the Lothian area since they left school. He has found that among boys, drug abuse rose to 37% in 1983 from 15% in 1979. For girls, the figures rose to 23% from 11% in the same period.

Wine is worse than cognac for ulcer patients: study

By Lynn Payer

NEW YORK — Patients with ulcers may be able to drink whisky and cognac, but should avoid beer or white wine, a study by a West German gastroenterologist says.

Manfred Singer, MD, and colleagues at the University of Essen, West Germany, maintain that — at least in healthy volunteers — white wine and beer greatly increase gastric acid secretion. Cognac and whisky do not.

In an earlier study, the group showed that lower concentrations of ethanol stimulate gastric acid secretion to a much greater extent than do higher concentrations. Six healthy volunteers were given various concentrations of ethanol orally, after which gastric acid secretion was measured by intragastric titration. Solutions containing 1.4% and 4% ethanol significantly increased gastric acid output compared to that seen with water and various glucose solutions used to control for volume and calories. However, ethanol concentrations from 5% to 40% had no effect and perhaps even an inhibitory one, Dr Singer said.

In a more recent study using the same method, the volunteers were given either 500 millilitres of beer, white wine, or distilled water, or 125 ml of cognac or whisky.

Beer increased the 60-minute incremental gastric acid response to 97% of maximal acid output, and wine to 61% of maximal acid output. Neither cognac nor whisky stimulated gastric acid secretion.

The practical result of the finding, Dr Singer said, is that "it might be okay for an ulcer patient to drink cognac and whisky: it is surely not okay to drink beer and wine."

Canada nominates INCB member

OTTAWA — Canada has nominated Donald M. Smith, PhD, for membership on the United Nations International Narcotics Control Board (INCB).

Dr Smith, who retired in January as senior scientific advisor, intergovernmental and international affairs, Health and Welfare Canada, is considered one of Canada's leading authorities on national and international narcotics matters and a senior statesman in the drug field internationally.

He has led Canada's delegation to the United Nations Commission on Narcotic Drugs for many years and, in 1979, served as chairman.

The 13-member INCB supervises implementation of the UN drug treaties, helping to coordinate national control measures and, where necessary, assisting authorities to conform to the treaties; analyzing information supplied by governments under the treaties; and, scrutinizing estimates and statistical returns prescribed by the treaties.

Smith: senior statesman

Under a complex system, three members are nominees of the World Health Organization; the remainder are country-nominees with overlapping five-year terms distributed to ensure adequate regional and technical expertise on the board.

From a potentially large number of nominees proposed to the UN Secretary General, a selection committee narrows down the list of candidates to twice the number of vacancies.

This year, there are five country-places on the board. Final elections will take place at the May meeting in New York of the UN Economic and Social Council.

NEWS

UK citizen action building against drunk driving

By Alan Massam

LONDON — People in Britain may tolerate excessive alcohol use, but many now draw the line at drunk driving.

That's one eonelusion that can be drawn from the success of the newly-formed pressure group, Campaign Against Drunken Driving (CADD), set up in the English Midlands.

Spokesman Graham Buxton told **The Journal**: "We are enraged at the failure of our legislators and courts to pass and enforce laws that will protect us from death and injury at the hands of drunk drivers.

"We want it stopped. We want tougher judges and tougher courts. A drunken driver is a potential killer, a threat to innocent people, a dangerous criminal at large in our society."

He adds: "Since launching the campaign, we have been overwhelmed with the response from organizations offering help and, in particular, from victims' families. In every ease, the families have been completely dissatisfied with the outcome of eriminal proeeedings. The penalties imposed bear no relation to the gravity and eonsequences of the actions of offending drivers."

CADD wants:

- bail allowed after a positive breath test only on eondition that the driver's licenee is surrendered prior to the ease being heard;
- cases against drunk drivers heard quiekly — in weeks rather than months;
- the amount of alcohol legally allowed in a driver's blood gradually reduced until the limit is zero;
- charges of manslaughter brought against drunk drivers who kill;
- eourt eases involving drunk drivers monitored and protested if a sentenee is only token or trivial; and,
- the law changed to allow the victim of a drunk-driving accident the right of appeal in the same way as a criminal can appeal.

CADD is also preparing an information booklet for vietims' families indieating their rights.

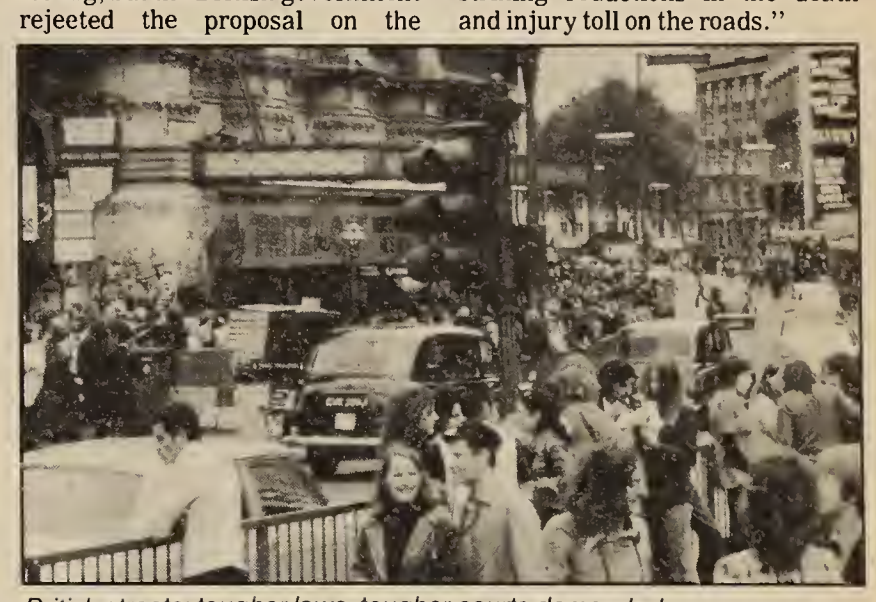
Mr Buxton, a retired police superintendent from Worchestershire county, operates CADD with a retired sehoolmaster from Cambridge, John Knight. Both had deaths in their families because of drunk driving.

The CADD initiative is given weight by a recent research study published by the Institute of Aleohol Studies. In it, James A. Dunbar, director of the Tayside (Scotland) Safe Driving Projeet, notes that if terrorists killed as many people in Britain as do drunk drivers, there would be public outrage. Dr Dunbar says about half the deaths and injuries to drivers, passengers, and pedestrians in the United Kingdom are linked with alcohol — a total of about 1,200 fatalities annually.

Dr Dunbar says the main reason for the high level of drinking and driving in the UK is that drivers reeognize they can get away with it.

Both the Blennerhassett committee of 1974 and the Central Poliey Review Staff (Think Tank) [**The Journal**, May, 1983] recognized the deterrent value of random breath testing, but the British government rejeeted the proposal on the grounds that poliee resourees were not available and that it would infringe civil liberties.

Dr Dunbar eoncludes: "The UK is now one of the few advaneed countries without random roadside testing and, in all countries where it has been introduced, it has led to striking reductions in the death and injury toll on the roads."



British streets: tougher laws, tougher courts demanded

GILBERT

Drugs and aging

I am writing this column on my 46th birthday — old enough to be curious about how drug effects change with age, and old enough too to suspect that they do.

Adult use of popular drugs — alcohol, nicotine, caffeine — appears to deeline with age, although few studies have confirmed this trend with certainty. The sure test is to study a cohort from birth to death. noting eonsumption at each age, an expensive teehnique that has been rarely used.

The alternative technique — to examine a cross-section of the population and note differences in consumption with age — is flawed. An apparent deeline in use by older groups may not reflect an actual decline in consumption by individuals. Consumption by older groups may be lower beeause death has removed heavy users from these groups.

Prescription and over-the-eounter drugs, by contrast, are used more as age advances — to seeure sleep, soften arthritis, reduce high blood pressure, and generally heal the ravages of time and unwise living. Instruetions as to the use of these drugs rarely take altered responsiveness with age into account. Specific instructions and special formulations will appear as the population's age and knowledge grow.

Greying society

A greying society, and one more eoncerned about being grey, will eause gerontological pharmacology to beeome a rewarding specialty. Clever researehers have recognized the trends for years. At the Addiction Research Foundation, Sarah J. Saunders, MD, has concerned herself with the widespread phenomenon of problem drinking in homes for the aged — the result of circumstances rather than age itself (see page 1). Drs Edward Sellers and Richard Frecker have published extensively on drug metabolism and aging.

There is no simple answer to the question of how the effects of a drug ehange as a person ages. Many faetors are involved. Some enhance drug effects. Some diminish them. Different faetors may be important for different individuals and different drugs. Here is a brief survey of what is involved.

More fat

Older bodies tend to have a higher proportion of fat than younger bodies, espeeially those of women. Drugs sueh as alcohol, nieotine, and caffeine that distribute throughout lean body mass will tend to have a stronger effeet for this reason. For example, in a recent Swedish study, equivalent doses of alcohol (0.68 grams per kilogram of body weight) produeed higher blood-aleohol levels and higher subjeetive intoxication seores in 50- to 59-year-old men than in 20- to 29-year-old men. Drugs that are highly lipid soluble (certain anesthetics and steroid hormones, for example) may have a weaker effeet with age beeause there is more body fat in which to distribute them.

Liver size declines with age. This and redueed cardiae output cause blood flow through the liver to decline by as much as 45%. As a result, the metabolism of certain drugs including alcohol could be slower. The evidence appears contradictory. For example, in the Swedish study just mentioned, the time course of disappearance of alcohol from the body was the same in 50- to 59-year-old subjeets as in 20- to 29-year-old subjects.

. . . a surfeit of speculation . . . because little is known about drug effects and use during the later decades of life

Liver enzymes

The enzymes in the liver responsible for metabolizing drugs may be reduced with age both in quantity (because of reduced liver size) and in effectiveness, but the evidence here too is slight and eontradietory. A recent review concludes: "None of the usual clinical tests of hepatie function are importantly altered in healthy elderly individuals."

Although older people may not neeessarily exhibit reduced enzyme activity in their livers, they do appear to show less in the way of increased enzyme activity as a result of coneurrent drug use. This loss shows most elearly in the case of smoking. Young smokers metabolize most drugs relatively quickly. They usually require a larger dose of a drug to achieve a given effect. The enhaneed metabolism occurs because the substances reaehing the blood after inhalation of tobaeeo smoke induce extensive activity in the liver enzymes responsible for the metabolism of a wide range of drugs. Older smokers do not show sueh enhaneed drug metabolism.

Kidneys smaller

The kidneys too decline in size — by about a third between ages 20 and 70 years. The "glomerular filtration rate," the rate at which the kidneys filter waste from the blood, declines by a similar amount. Thus, drugs sueh as penieillin that are mostly excreted intaet in this way, rather than metabolized, will stay longer in the body. A given dose may, as a result, be more effective in the elderly.

A similar consideration arises in the case of caffeine which is mostly metabolized, but whose metabolites may have similar properties to the drug while they are cireulating in the body before exeretion by the kidneys. A given dose of caffeine may have a stronger effect in older people in part because eaffeine's metabolites, ehiefly 1-methylxanthine, are exereted more slowly.

Caffeine itself, as opposed to its metabolites, is one of many drugs that the liver seems to handle as effieiently in old age as in young adulthood. Thus, the frequently observed falling off in caffeine-beverage use among elderly users must have other causes — perhaps the reduced rate of elimination of metabolites diseussed in the previous paragraph, or increased sensitivity of the central nervous system to caffeine. (Ineidentally, children between six months of age and puberty are more effieient metabolizers of caffeine than adults.)

CNS sensitivity

Inereased sensitivity of the nervous system seems to be a faetor in the increase in effectiveness of the minor tranquillizer diazepam (Valium) with age. A 1984 British study examined the dose of intravenous diazepam required for sedation in patients aged 17 to 85 years. Patients aged 80 years were sedated with one-third of the dose required to sedate 20 year olds (10 vs 30 milligrams). After reeeiving one-third of the 20 year olds' dose, the 80 year olds had between one-third and one-half the concentration of diazepam in the blood. Beeause reduced metabolism or redueed elearanee of diazepam, or both, was insufficient to aeeount for the increased sensitivity to the drug among the older patients, the only reasonable eonelusion was that the older nervous system is more sensitive to the drug.

Inereased sensitivity of the brain to drugs is not what you might expeet with age, for two reasons. The first is the widespread phcnomenon of tolerance to drug effects. Repeated use of a drug usually leads to a lessening of its effects on the user and to a lessening in the effeets of related drugs. Older pcople might be expected to show tolerance and thus relative insensitivity to the effects of many drugs, especially in view of the large number of drugs taken therapeutically by many elderly people.

The seeond reason for not expeeting increased sensitivity of the brain to drugs lies in the familiar decline in the functioning of the nervous system with age. Senses fail and intellectual aetivity slows down. According to this line of reasoning, reactions to drugs should diminish with age in much the same way as reactions to sounds diminish with age.

Complex responses

Responses to drugs, however, are in some ways more complex than responses to physical stimuli. The neural response to caffeine, for example, is now believed to depend on the bloeking of adenosine, a chemical in the brain involved in neural transmission. High levels of adenosine are associated with lethargy and sleep, and also reduced heart rate, blood pressure, and body temperature.

During normal brain activity, adenosine appears to inhibit the release of chemicals that carry messages from one nerve eell to another. Caffeine prevents adenosine from doing its work and thus stimulates neural activity — so researchers believe. If the responsiveness of the adenosine system declines with age, caffeine may beeome a more effective blocker of adenosine with age. Certainly caffeine's ability to raise blood pressure appears to be greater in older than in younger adults.

Toxic assaults

Yet another faetor in drug action and use is the response to toxic effects of large drug doses. The older body is weaker and perhaps less able to withstand the immediate assaults of overdoses or the delayed assaults known as hangovers. Inability to eope with toxicity may account for reduced tobaceo use among elderly people and, together with the factors mentioned above, for reduced aleohol use. Moreover, older people have had more time in whieh to learn to avoid excess. They may put their learning to good use.

There is a surfeit of speculation in this column, becausc little is known about drug effects and use during the later deeades of life. By thc time my children are 46 years old, I expect they will bc able to have a mueh better idea about what is in store for them should they too become curious about drug cffeets and aging.

By Richard Gilbert

NEWS

WHO sees more anti-tobacco law on horizon

Costs could shift to manufacturers

By Thomas Land

GENEVA — The United Nations World Health Organization (WHO) predicts a wave of financial legislation in Western Europe and North America shifting liability for the costs of smoking from the taxpayer to the tobacco companies.

The WHO has committed the collective support of the medical profession to the global anti-smoking campaign in its fight against the tobacco companies now before the courts.

In Sweden, the National Social Insurance High Court has just accepted that passive smoking as a potential cause of lung cancer can be classified as industrial injury. The decision, won posthumously by a lung-cancer victim, is expected to have wide-ranging social and industrial repercussions.

In the United States, a wave of about 30 product liability and personal injury lawsuits is about to reach the courts as petitioners try to establish the responsibility of the tobacco industry for ill health and deaths of smokers.

A front-page editorial in *Tobacco Alert*, a publication the WHO publishes here, declares: "One of the most encouraging signs of the changing social climate in regard to smoking is the way in which judges and juries are revising their attitudes to liability suits. In some ways, such changes reflect the growing power of the consumer to make his voice heard in the courts.

"But, it also indicates the extent to which even such conservative bodies as legislatures in North America and Western Europe have come to accept the sheer weight of the medical evidence for the association between smoking and major diseases." ("The financial experts of the world's stock exchanges have also studied the evidence and, as a consequence, cigarette stocks have shown sharp price declines as nervous investors await the outcome of the lawsuits against the major tobacco companies," adds the editorial.)

Success in court by the anti-smoking lobby, says the WHO, may well encourage governments to consider new forms of legislation to shift the medical costs linked with smoking to the tobacco industry. At present, the bills are paid by the taxpayer. A single North American smoker is reckoned to cost his employer alone an extra $4,600 a year in health and life insurance, absenteeism, wasted time, and cleaning.

The verdict of the Swedish court has already led to widespread demands for a ban on smoking in the workplace. It has provided fresh grounds for non-smokers to refuse employment in smoke-polluted industrial premises. A rash of new claims is now expected for industrial damages by non-smokers who believe they have contracted lung cancer or other diseases from passive smoking.

This is likely to induce employers to avoid the whole issue by insisting that all employees refrain from smoking.

The tobacco industry's standard defence to litigation rests on an assertion of the smoker's right to smoke. The industry also denies the existence of any scientific evidence establishing the link between ill health and smoking.

But *World Health*, another journal the WHO publishes here, observes a trend discernible in North American court decisions "to award compensation if a product is determined to be dangerous. Even if a manufacturer has not been found to be negligent, a product is still assumed to carry an implied warranty that it is safe. Furthermore, (health) warnings on labels do not automatically exempt manufacturers of liability."

Core group of addicts remains numerically stable

Bromocriptine only 'promising' in treating coke users

By Harvey McConnell

NEW YORK — There may be a decline in the United States in the number of people who "ever used" cocaine, but the core group of addicted users remains stable.

And, while the dopamine antagonist, bromocriptine, has been shown in a pilot study to reduce craving in the early stages of treatment, it is not a "silver bullet" which will cure cocaine addiction.

These were major points made here at a clinical conference on cocaine by Arnold Washton, PhD, and Mark Gold, MD, founders of the 800-COCAINE hotline and respective research directors at the Regent Hospital, New York, and Fair Oaks Hospital, Summit, New Jersey (**The Journal**, November, 1985).

Dr Gold takes issue with those who suggest the cocaine epidemic is over. "Is it because only 25 million people in the United States have tried cocaine that experts are now saying the cocaine epidemic is over?"

That is almost like saying "the adolescent drug abuse epidemic is over because only one-third of the high school seniors have smoked marijuana in the preceding month and only one in 18 smoke marijuana every day."

Certainly, people in treatment settings don't see evidence that the cocaine epidemic is over: "All they see is more people coming into treatment."

Dr Gold suggests that while induction of new people into the category of ever using cocaine has shown some decline, "the core group of addicted users has been quite stable. And, there are enough new inductees to keep the core group of addicted users the same and still cause many people to go into treatment."

Dr Washton said that the clinical trials of bromocriptine among cocaine addicts shows it may help reverse post-cocaine dysphoria or reduce the craving for cocaine.

"But, bromocriptine is not the 'silver bullet' to cure cocaine addiction.

Gold: no single treatment

Washton: marketing strategy

"One thing that has become clear in treatment is that no single treatment method, no single medication, is going to take care of the addiction. Bromocriptine appears to be promising, but only as an aid in the early phase of treatment, where some individuals — especially high-dose freebasers and IV (intravenous) users — may otherwise be unable to achieve initial abstinence without pharmacological help."

Dr Gold, who reported on a bromocriptine trial at Fair Oaks in a recent issue of *The Lancet*, said the drug was first used to treat Parkinson's disease and amenorrhea galactorrhea, which is a low-dopamine infertility syndrome. The drug has changed the way researchers look at the brain neurotransmitter system and cocaine.

He explained: "Instead of thinking cocaine just blocks re-uptake, we see that it chronically depletes dopamine in the brain and affects essential neurotransmitters which are important in mood, energy, concentration, and motivation."

Dr Washton said that "crack" (rock-like cocaine freebase ready to smoke) is being sold in affluent Westchester County, New York, to high school students for $20.

The low price may be part of a marketing strategy on the part of drug dealers. Dr Gold: "What better way to get large numbers of people addicted than to sell the most addictive form of the drug as cheaply as possible?"

Dr Washton said recent experience on the 800-COCAINE hotline leads the researchers to believe there will be an upsurge in freebase smoking in the US because intravenous cocaine users, fearful of AIDS (acquired immune deficiency syndrome), are now switching.

"They have discovered they can switch to freebase to get the same intense, rapid, euphoric high without the risk of using needles."

The clinical conference on cocaine was sponsored by Regent and Fair Oaks hospitals, the American Medical Society on Alcoholism and other Drug Dependencies, and US Journal Training Inc.

HOWELL

The smoker as scapegoat

There has been much discussion of late about the deleterious effects of cigarette smoking in the workplace. Many employers are following the lead of health care organizations and governments and are taking steps to create smoke-free work environments, spurred along by court and tribunal decisions to the effect that sidestream smoke is a demonstrable health hazard.

My friend, Professor Bottomsworthy, is all in favor of eliminating smoke from the work environment. He agrees it is a health hazard. However, he worries about the long-term effects of eliminating smokers from the work environment.

In this regard, he makes reference to Richard Nixon's bitter "farewell to the press" speech of 1962, when he said: "For 16 years you've had a lot of fun . . . just think about how much you're going to be missing: you won't have Nixon to kick around anymore, because, gentlemen, this is my last press conference."

Professor Bottomsworthy is concerned about what will happen when we don't have smokers to kick around anymore, especially because, unlike Mr Nixon, they are unlikely to make a comeback.

"Imagine," he says, "what it will be like when there are no smokers in the workplace. That will mean there will be nobody the self-righteous can badger and harass with impunity. You cannot harass people because of sex, race, or religion — there are laws against that. And, even though there are no laws prohibiting it, the hectoring of alcoholics or other drug abusers is considered bad form.

"But smokers — ah, smokers, those perverse polluters, those self-admitted self-destructors — you can say anything you want to them. They are beyond the pale of human rights legislation and, in any event, all the fight went out of them years ago. They know that smoking causes lung cancer, emphysema, and assorted other ills.

"They won't argue with you or try to justify themselves. If you smugly tell them they are killing themselves, they will just smile sheepishly and agree with you. They are a good source of office amusement and diversion. Catch one sneaking a weed where he shouldn't, and watch his guilty face flush. Corner one who is doing her best to fight the habit, say something like 'Hey, I'll bet you could really use a cigarette,' and watch her squirm.

"Smokers are the modern-day equivalent of the dwarfs and hunchbacks who used to be kept around royal courts for sport and amusement. And even though they lack humps you can pat for good luck, they still make pretty good pariahs."

Although the professor is concerned about what will happen when the smoker disappears as a modern workplace pariah — he worries that when the easy target of the smoker is removed, the self-righteous will seek more traditional game, notwithstanding that human rights legislation has attempted to place such game off-limits — he is equally concerned about what will happen when the smoker disappears as scapegoat.

"Imagine," he says, "what will happen when people can no longer blame productivity deficiencies on high carbon monoxide levels or other toxic effluents produced by a tobacco addict at the next desk. When management can legitimately certify that the air is pure, it can also legitimately ask that employees produce what they said they were capable of producing, were it not for the foul and filthy atmosphere created by the smokers."

This, of course, will lead to an intolerable situation in the workplace. Without smokers, there will be a "scapegoat gap" that will be difficult to plug. Perhaps it can be plugged by references to the alleged ionizing radiation of video display terminals, but this remains to be seen. Human scapegoats are always more convincing than inanimate ones.

Having given the question some thought, the Professor offers this suggestion: "Notwithstanding the benefits of a smoke-free workplace, there are certain benefits to be gained by maintaining at least one token smoker in the workplace, someone who can serve as both a pariah and a scapegoat. The psychological benefits to be gained by having this person available for abuse and excuse might well exceed the physiological benefits to be gained by having a pristine-pure environment."

By Wayne Howell

EAP technology: creating a separate place

The need to contain climbing health care costs is affecting the aims and day-to-day operations of all sectors of health care delivery systems in North America today.

Employee assistance programs (EAPs) could be the exception to the financial rule of escalating costs: EAP theorists point to statistics to prove EAPs are cost-effective in cutting health care costs associated with substance abusers.

This success, however, is resulting in a quandary for EAP practitioners: to what extent should the field become a part of health care delivery systems?

In Canada, the federal health ministry is looking at EAPs in a new light. Maureen Law, MD, associate deputy minister, Health and Welfare Canada, said last fall the workplace could become an important setting for assessing — and providing — special health care needs for Canadians as governments face up to harsh economic realities (The Journal, December, 1985).

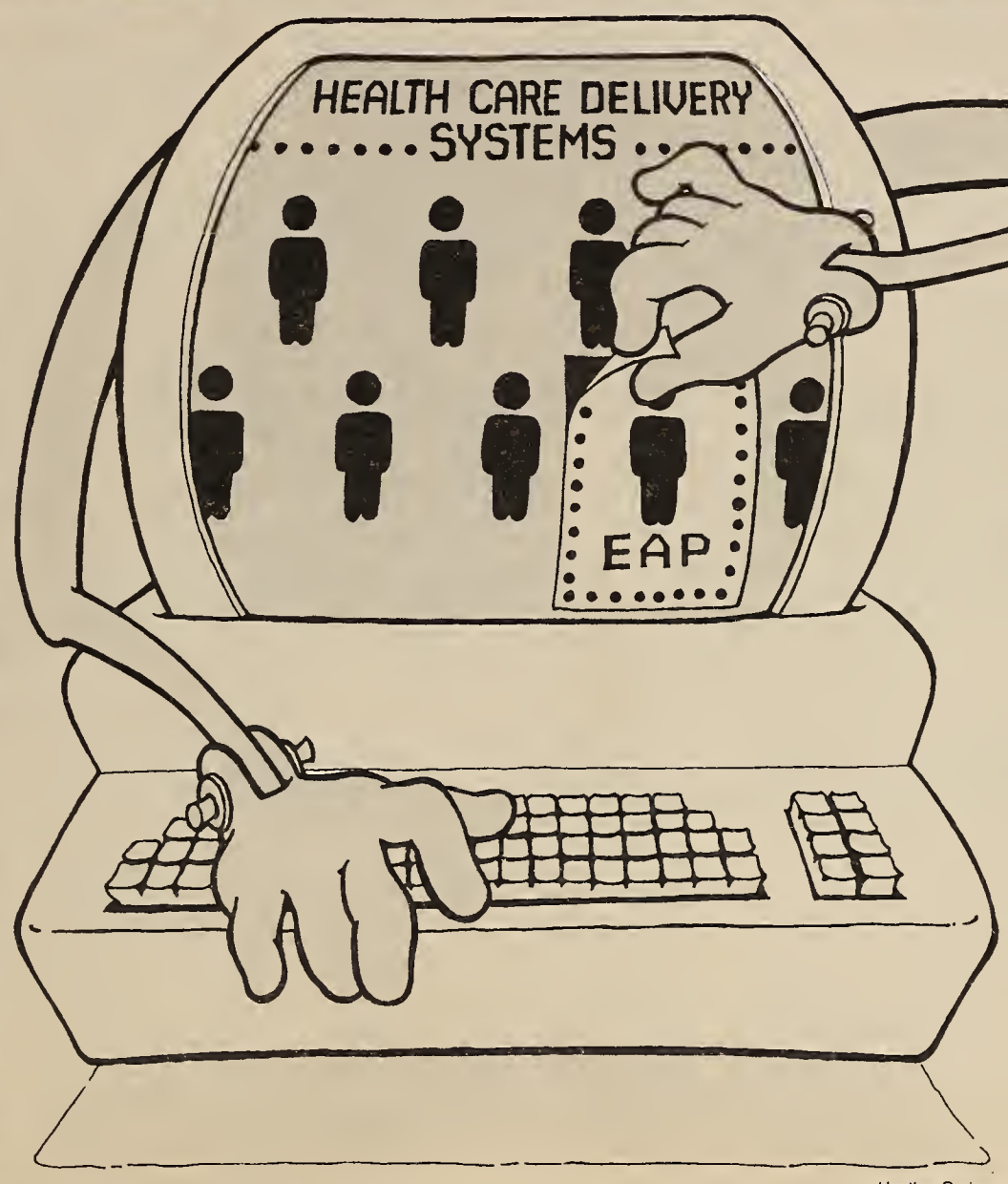
In the United States, increasingly-competitive markets for private — and costly — health care delivery (The Journal, November, 1985) means treatment organizations are eager to offer clients external EAPs as part of their services.

Researchers at the Alcohol Research Center, Tulane University, New Orleans, have been collecting data on EAPs since the 70s, tracking EAP practitioners, the programs they use, and growth within the field. They have now completed a survey of 480 company EAP locations — each with at least 500 employees — across six states.

Paul Roman, PhD, is coordinator of the Tulane centre, a professor of sociology and human relations at the university, and an EAP researcher for 20 years. He says the question of whether or not EAPs are health care activities is pivotal.

Hauschildt

He suggests EAPs retain their separate and special identity and explained why to a workshop at INPUT 85, the 6th Biennial Education Symposium on EAPs in the Workplace. Managing editor Elda Hauschildt reports.



Heather Graham

OTTAWA — EAP practitioners should use the core technology intrinsic to the field — the activities that differentiate EAPs from other sectors of health care delivery systems — to build up their separate identity.

"We shouldn't be defining ourselves into a corner saying we are a routine, understandable, continuous part of health care delivery systems," Paul Roman, told the EAP conference here.

"We should be defining our work more distinctly."

Dr Roman points out six activities new to the workplace — "six activities that did not go on before" — that form the EAP field's core technology.

"If similar activities did go on before EAPs, they went on in such a rudimentary, unorganized fashion that we really did not understand what was happening."

Like the computer, EAPs are an invention, Dr Roman suggests. But unlike computers, they are a "social" invention.

"In EAPs, we have social inventions built in that are of critical value to the workplace — to companies, management, unions, labor — because they solve problems in a way in which they were not solved before."

Dr Roman says the difficulty EAP practitioners have in dealing with the question of their role within health care delivery can be understood by looking at two concepts.

"Many people have difficulty with the notion that EAPs are not a central part of health care, or at least that their central identification is not with health care delivery systems.

"But, I think fewer numbers of people have problems with the statement that EAPs are just another strategy of personnel management, just another tool that personnel managers should have in their kits: people in EAP work would say we do much more than that.

"So, defining EAPs as a personnel strategy isn't going to work."

As well, Dr Roman says, EAPs must maintain relationships with health care delivery systems. And, EAP practitioners need to know as much as possible about the health care delivery system affecting both the companies they operate in and the communities within which the companies exist.

"We have as big a 'foot' in the workplace as we do in the treatment place. Probably an even more important set of skills for EAP professionals to have centres around their knowledge of the worksite, as contrasted to any intimate knowledge of how to do clinical work."

For example, Dr Roman emphasizes the differences between EAPs and wellness programs.

"I shudder when I hear people say that wellness programs and EAPs are the same thing. Or, that wellness programs and EAPs should be combined. They are very different kinds of strategies and have very different kinds of technologies."

The six activities through which Dr Roman categorizes the EAP field's core technology are: job performance-based identification, supervisory/shop steward consultation, constructive confrontation, micro linkage to treatment, macro linkage to treatment, and practical solutions to alcohol and other drug abuse problems.

• Job performance-based identification

"Through the job performance-based identification mechanism — which we invented in this field — we tell supervisors they are to identify people for EAPs via performance problems and to stay away from the issues that appear to be clinical issues," Dr Roman explains.

"With this mechanism, we have a significant way of dealing with substance abuse problems — and other problems of denial — by zeroing in on people's performance.

"The beauty of this is that it requires supervisors and shop stewards or other people in the workplace simply to do their job assignments. They do not have to develop new ways of doing things, new technology."

Job performance-based identification "gets companies out of the treatment business" if EAPs are effective, Dr Roman says.

"If you don't have an EAP, you are providing treatment to substance-abusing and other troubled employees through your supervisors, shop stewards, managers, personnel department, occupational nurse — in a very inefficient way."

Fundamentally, an EAP takes the job of counselling employees — "particularly the job of dealing with substance abusers" — out of the hands of people within the company and into the hands of people outside of the company better equipped to deal with such problems.

• Supervisory/shop steward consultation

Dr Roman says when an EAP is working correctly, the EAP coordinator — whether external or internal — "gets a lot of phone calls from a lot of supervisory and union people asking advice on what they ought to be doing with a certain individual."

EAP coordinators find this consultation takes up approximately 50% of their time, which Dr Roman says is as it should be.

"One of the worst assumptions that can ever get into EAP work is the suggestion that an EAP carries out supervisory/shop steward training with the idea that those supervisors/shop stewards will then be equipped to make a referral to an EAP.

"What we really want to do is to give supervisors/shop stewards enough knowledge of how a program works and who the key people are in terms of the coordinator or joint committee so that they can contact the right person for advice when they think they need to use the program."

• Constructive confrontation

This mechanism "goes contrary to people's basic disposition about how to deal with somebody in trouble," Dr Roman says.

Constructive confrontation — "creating a crisis" — adapts itself to the workplace through the EAP technology of job performance-based identification.

"When we use job performance-based identification, we have documentation about performance, attendance, relationships with other employees, quality of output, etc — the teeth necessary to produce a real, constructive confrontation and give the person a choice."

• Micro linkage to treatment

This EAP activity links individual employees with the community resources best suited to deal with their problems, given the characteristics surrounding their jobs.

Dr Roman: "Well-intended strategies fall flat on their faces because the person involved in giving the individual help doesn't understand the demands of the individual's job, job situation, and relationships with co-workers. The individual may get treatment but doesn't have a job left."

This "critical point" revolves around the EAP coordinator understanding "realistic aspects of the workplace," Dr Roman says. And, he suggests EAP professionals can "move themselves light years ahead" by saying they are dealing with employees or workers, not clients.

• Macro linkage to treatment

"Macro linkage is a technique which says that the EAP specialist has the 'wherewithal' to help organizations decide which treatment and counselling groups within the community should be used on a long-term basis," Dr Roman explains.

He says EAP specialists must maintain adequate records on how cases are handled and what the outcomes are, rather than depending on personal impressions.

"Otherwise you get huge halo effects associated with certain experiences: one individual was turned around so dramatically at a treatment centre that you forget about the other five cases that didn't turn out as well."

Data-based analyses are best for macro linkage to treatment, Dr Roman says.

Macro linkage to treatment also points out "the vital interdependency with treatment," he suggests.

"There is a partnership between treatment organizations and employers, but it is a partnership that has to be brokered by someone who knows the track record of treatment in terms of specific records in a specific system of information.

"That someone needs to know the workplace and its requirements too because of the control issues built into both micro and macro linkages to treatment — the appropriate passage of information within the context of confidentiality, for example."

• Practical solutions

The EAP field is the only field offering constructive solutions to alcohol and other drug abuse problems, Dr Roman says, noting other so-called solutions are punitive, negative, and judgmental in style.

"You'd be amazed how much people outside the field are impressed with the fact that we can offer constructive solutions that usually carry with them continuity of job performance, career, and family."

Roman: a social invention

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Colorado research contradicts Washington report

Inhalant abuse by Native youth still high

I heard that at a recent Washington meeting a report was made to administrators of NIDA (United States National Institute on Drug Abuse) and ADAMHA (US Alcohol, Drug Abuse and Mental Health Administration) indicating minorities no longer used inhalants more than non-minorities.

I am deeply concerned about this report, since it is patently untrue. If policy decisions were based on this fallacious idea, they could be inappropriate and damaging. I have, therefore, described my concerns, in a letter to the administrators of NIDA and ADAMHA, to Carleton Turner, PhD, director of the White House Office on Drug Abuse Policy, and to some legislators who head up committees related to drug use.

Would you please consider including this information in **The Journal**?

I believe it is very important to communicate the fact that inhalant use is definitely still a serious and continuing problem for Indian youth. A more general concern is that misinformation about minority drug use rates, such as ignoring real differences, may lead to a decreased emphasis on the need for continuing study of minority groups.

To explain: The US national household survey shows that lifetime prevalence of inhalant use for 12 to 17 year olds is near 10%. For this age group of reservation Indian youth it is now near 30%.

The US national senior survey shows that less than 2% of high school seniors used inhalants during the month prior to taking the survey. By contrast, 10% of Indian seniors used inhalants during the last month.

Inhalants are still a serious problem for Indian youth. Furthermore, our current data show that, while other drug use is dropping for Indian youth, use of inhalants is not decreasing.

Why can one report suggest no differences while our data show large differences? One reason may be age of the subjects. Inhalants are used by the young, and tend to be the drug of choice of the very young. Older samples may show few or no differences.

A second reason may be sociocultural differences in the samples. Extreme rates of inhalant use seem to be found in situations where a minority and highly disadvantaged group is physically or culturally isolated, particularly when there are language as well as economic and cultural differences — notably the Hispanic barrios of the big cities and Indian reservations.

If you want further information or data, please call me at (303) 491-6827. Mike Backenheimer is our NIDA project officer and would also have copies of our articles and reports.

E.R. Oetting
Professor of Psychology
Colorado State University
Fort Collins, Colo

Minnesota also battling grocery wine and beer

Having just read the outstanding article, Beer and Wine in Grocery Stores: The Implications (November, 1985), I wish to obtain the reference material you offer to provide in the article postscript.

We have been fighting the grocery industry and the California Wine Institute to keep wine (and ultimately beer) out of Minnesota grocery stores for years.

Minnesota is unique in that about half of our cities have typical, private-enterprise liquor licences. For the other half (my half), the city owns and operates the licence as another city department.

Our historical legal justification for these Municipal Liquor Stores has always been control, though the profit picture has become more important in recent years. Most of our facilities are state of the art. And, since we try to be first-rate merchandisers, our financial results are probably the largest body of actual retail liquor statistics available in the United States.

Lyndon M. Griffin,
Executive Secretary
Minnesota Municipal Liquor Stores Association, Inc
Bloomington, Minn

Driver-ed is not all bad

I am writing about your article, Student driver courses backfire (November, 1985).

I am disturbed that the headline implies this is true right across Canada, whereas, the article discusses only Alberta. The research was done by the University of Calgary within Alberta.

Laws regarding seat belts, drinking and driving, and many other factors are under provincial jurisdiction, and Alberta's are quite different from Ontario's. Therefore, I feel that the heading of your article should read, Student driver courses backfire in Alberta.

As a driving instructor in Ontario, I resent the fact you are making broad, sweeping statements about driver education courses which are not true. Just because one province is having a problem is no reason to associate this problem with all of Canada.

It would be much appreciated if you could refrain from this biased journalism. And, I feel a retraction is in order for all the driving instructors in Ontario, who, I think, deserve some positive reinforcement rather than destructive criticism.

Don R. Derraugh
Arnprior, Ont

Windsor offers DWI course too

I read with interest the article entitled Courses augment DWI probation (November, 1985).

I would like to advise that Windsor has had a driving-while-impaired program since October, 1980, known as the Drinking Drivers and Alcohol Awareness Program.

This program was patterned after a Chatham program which, in turn, was patterned after one developed by Ontario's Addiction Research Foundation.

(Some 300 people have participated in the seven-week program since it began.)

David A. Walsh
Probation/Parole Officer
Ministry of Correctional Services
Windsor, Ont

Our mistake

The drinking and drugs radio program (January) is offered by Open College, CJRT FM in conjunction with Ontario's Addiction Research Foundation. CJRT FM is an independent educational radio station.

Issues of responsible beverage service

Bars and restaurants in the United States have been pushed to the forefront of the drinking driving controversy: some have been sued after intoxicated customers were involved in fatal road accidents; some states have restricted happy hours; liquor liability insurance has risen to such phenomenal rates that many small establishments "go bare."

Leaders of the hospitality industry have instituted a number of programs to help promote more responsible drinking by customers and more responsible serving practices by bartenders and other employees.

Surveys show the public is drinking less and switching to lighter drinks. There is major marketing of non-alcoholic beers such as US-produced Texas Select, European imports Moussy and Warteck, and fruit-flavored mineral water.

A recent conference in Cambridge, Massachusetts, on Responsible Beverage Service — Issues for the Future, sponsored by the non-profit Center for Responsible Hospitality, brought together leading figures in the hospitality industry and outside experts to consider the ramifications. Contributing editor Harvey McConnell reports on discussions of underage drinking, merchandising options, server training, consumer responsibility, and happy hour restrictions.

McConnell

CAMBRIDGE, Mass — Underage drinkers are a problem. But, where does the responsibility lie?

Bill Baird Griffith, a minister and presiding judge for the probate and juvenile courts in Putnam County, Tennessee, is a member of the substance abuse committee of the US National Council of Juvenile and Family Court Judges. He is also a member of the Tennessee governor's Task Force on Youth, Alcohol, and Drugs.

Judge Griffith told the conference here: "I am constantly looking for places to place the responsibility.

"When I have, as I did recently, a 17-year-old male before me, arrested in a tavern, and who has brown hair, brown eyes, stands five feet 10 inches tall, and weighs 145 pounds sopping wet, and he was in that tavern on an ID (identity card) describing a blond, blue-eyed male, six feet one, and weighing 200 pounds, I start looking for places to attach responsibility."

The young person "is not to be neglected in the matter of responsibility; it is he who flagrantly, frequently, and deliberately broke the law," he says.

Also responsible, in part, are parents "who do not know where their young people are."

Judge Griffith adds to the list: schools which teach little to students about alcohol and other drugs; police, lawyers, and judges who often turn a blind eye to use and abuse of alcohol by underage drinkers; brewers and distillers who spend billions trying to brainwash young people into thinking their products are the keys to the good life, success, and satisfaction; and the retailer who sells alcohol to a 17-year-old on a manifestly fraudulent ID.

Judge Griffith says that more often than not laws that are more punitive to the seller than the consumer, as in Tennessee, are not right. However, the scales generally tilt the other way; the consumer is arrested, tried, and convicted, and seldom is anything done to the seller and server.

"There needs to be more balance in both written law and in enforcement. There is no right way to do a wrong thing, and underage drinking is illegal."

Louis Munch, PhD, associate professor, Ithaca College, Ithaca, NY, and a specialist in psychoactive drugs and on the issue of a legal drinking age, says any measures which reduce alcohol consumption in 18 to 22 year olds will reduce some of the problems. But, there will remain a conflict between the economic issues of the industry and issues of public health.

The only acceptable ID is a driver's licence because college IDs are easy to alter or change. There is a need to develop a "tamper proof" ID.

Dr Munch says incoming customers can be made to sign forms declaring they are of legal drinking age, with added protection if the number of the driver's licence is recorded as well.

Law enforcement can have a major impact. Dr Munch says in his county in New York, the district attorney is vigorously prosecuting those who present fake IDs. Those found guilty can be fined up to $1,000 and given a maximum of a year in jail.

Merchandising options

Patrick Nilson, a vice-president of Joseph E. Seagram and Sons, distillers, which had sales in fiscal 1984 in excess of $2.8 billion, says a majority of people in the US enjoy beverage alcohol without problems, and only recently have consumers been made aware of their responsibility as alcohol drinkers.

His company has produced charts on blood alcohol/body weight which, he says, have increased consumer awareness: "Everybody knows how much they weigh, but not everybody understands how much they can safely drink."

In 1985, the company developed "equivalency advertisements" saying that approximately 12 ounces of beer, five ounces of wine, and 1.4 ounces of spirits have identical amounts of alcohol. But the ads came into conflict with the television networks.

The company wants to educate the public "because not understanding these facts can cost lives," Mr Nilson says.

However, the equivalency ads have been rejected for television because they are said to be aimed at selling liquor, even though the distillers said they would remove the company name. The company, nevertheless, will continue to present the message in print and on cable television.

Mr Nilson says more and more people in the industry are realizing there is profit in non-alcohol and low-alcohol drinks and in promoting high-price premium brands. His company has produced a range of non-alcohol wines and devised a number of "mocktails."

Mr Nilson: "There is a new kind of customer appearing in growing numbers. They are out for a quality evening and looking to enjoy the social environment of a bar, but they may want to consume only a small amount of alcohol, or possibly no alcohol at all."

Fruit-flavored drinks without alcohol, or innovative creations, provide customers with an alternative, limit liability, and generate more profits because prices can be higher than those for traditional soft drinks.

The company produced non-alcohol wines following research which pointed to a market among wine drinkers 35 years and older, who are looking for an option on certain occasions. Wine coolers, diluted wine drinks, have also become popular,

and there are a number of brands on the market.

At the same time, non-alcohol, or low-alcohol drinks are not suitable for everyone: "That's fine. They don't have to be. Customers should be able to drink anything they like, as long as it is served and consumed responsibly," Mr Nilson says.

"People must understand that in this day and age we must find ways to maximize the profit out of each and every drink we sell a customer, rather than trying to sell him more drinks."

James Schaefer, PhD, director of alcohol and other drug abuse programs, University of Minnesota, Minneapolis, says focus must be kept on the problem, "and the problem in drunk-driving is the problem drinker, not the social drinker.

"I think we do ourselves a disservice when we dicker and argue about the fine points of social drinking. We need social drinkers as allies, as well as their social circles, to help influence the consequences of intoxicated behavior by problem drinkers. And, if we alienate the recovering alcoholics and the people who choose not to drink for whatever reason, as with social drinkers, we do ourselves a disservice."

Dr Schaefer says customers should be encouraged to spell out what they like: this is the best way to market both alcohol and non-alcohol drinks.

And the role of coffee drinking at the end of an evening should not be discounted, he says. While many people know it won't help them sober up, it does give an unmistakable signal to everyone that the evening's drinking is over.

David Waddington, owner of a lounge in Waterford, Connecticut, and chairman of the responsible beverage service committee of the Connecticut Cafe and Restaurant Liquor Council, says mocktails can sell in the $2.25 to $3.95 range, the same prices charged for many alcoholic drinks.

But, he warns: "If you and your staff have a negative attitude toward mocktails, they won't work. They should be treated exactly as any new alcoholic beverage on the market.

"Serving mocktails gives a better public image for the hospitality industry, and a better public image usually translates into increased customers and ultimately, increased profits. Offering mocktails as socially-acceptable drinks helps accomplish these goals."

He adds: "It is time now to consider ourselves not only as purveyors of alcoholic beverages, but as full service drinking establishments featuring both alcoholic and non-alcoholic beverages."

Server training

As for server training, says Carol King, president of the Quality Service Group, a Princeton, New Jersey consulting firm, the best is based on two assumptions: those who are trained can prevent people becoming impaired, and, if the patrons do become impaired, staff can prevent them from trying to drive home.

Servers must know when and how to in-

Responsible beverage service

(from page 9)

tervene effectively, she says.

In some bars, staff are in tune with the hard-drinking reputation the establishment may have. And, it may be difficult to get them to change.

In chain operations, staff do not question policy, and while they may be provided with certain procedures, there is a lack of communication to enable them to cut off service effectively.

In independent operations, management may be authoritarian; servers are frightened of angering guests and do not know what their responsibilities are.

In most states it is illegal, and has been for years, to serve anyone who appears intoxicated. If employees know something should be done and how to do it, but don't do it, this means "either they will get punished if they do it; get rewarded if they don't do it; don't see that doing something matters; or, there are some other obstacles."

Ms King says cutting off service can lead to problems with nasty drunks — or to a very large tip for serving another drink.

Although the impaired person may resent intervention, other customers see it as responsible behavior.

James McKnight, PhD, president of the non-profit National Public Service Research Institute (NPSRI) and member of the Transportation Research Board, a division of the US National Academy of Sciences, says NPSRI has done pilot runs, with ongoing revisions, of server training programs and hopes to field-test the program early this year. Research to date has involved several hundred people working in bars, restaurants, and hotels.

He says one of the biggest problems his group faces "is an acceptance on the part of servers that they have an obligation to the public to keep intoxicated people from leaving their establishments."

James Peters, founder and executive director of Intermissions Inc, Northampton, Mass, has been in the industry since graduating from the University of Massachusetts. He holds an advanced degree in psychology, specializing in alcohol and substance abuse counselling and education.

Mr Peters: "The promotion of alcoholic beverages in the 1960s and 1970s provided a tremendous opportunity for growth in the hospitality industry, but, to a certain extent, the industry was negligent — or not responsible — to certain social responsibilities they had in serving it."

A consequence has been an increase in legislation and strictures on happy hours.

Mr Peters says managers, as well as staff, need to be in training programs. In programs he has conducted, he has found managers perceive the problems as server problems. But, many servers complain they are often in conflict with managers if they try to do what they've been taught.

Mr Peters adds that if "through menus, signs, and staff training you let the customers know they have a wide variety of options available to them, that you are concerned about drinking and driving and you want to make sure they get home safely; that you are encouraging them to make decisions before they start to drink; and, that you're making the various options available to them, you are promoting consumer responsibility."

Consumer responsibility

"We host some of the largest cocktail parties in the world," quips Frank Rose, senior vice-president of Harry Stevens Inc, Robbinsville, NJ, a leading US concessionaire. Their accounts include service to

such large sports facilities as Giant Stadium, New York, NY, the Meadowlands complex, New Jersey, Candlestick Park, San Francisco, and Fenway Park, Boston.

His company accepts it has a responsibility not to serve alcohol to those who are underage and not to serve those who are obviously intoxicated. "But, it is not easy to enforce it all the time."

They "card" anyone asking to buy alcohol, whatever their age. "They have to provide a legitimate identification or we don't serve them. This has created some furor, but it is part of protecting ourselves."

It does not always work: the company was cited four times in 1985 for selling to underage customers, "all of whom had false IDs, and all of whom had been turned down more than once. However, we were responsible and were fined for that," Mr Rose adds.

One of the most important things employees are taught is that, as the licencee, "you have the absolute right to deny service, for no reason," to anybody. Those who protest not being sold alcohol are asked to go to the main office.

Another problem is tailgate parties in stadium parking lots before games. There is no control on who drinks what, how old the drinkers are, or of their state of intoxication when they enter the stadium. At the end of a game, many people sit in the parking lot drinking while the traffic thins out.

Some of these people may be involved in fatal automobile accidents. Thus, Mr Rose says, even though the company limits sales to two beers per customer, and several hours may have passed between the sale and the accident, his company could still be sued.

Last year, the company's insurance liability premiums jumped to $2.5 million from $1 million, and they will go higher. "The consumers are ultimately the people who pay for that, because we have to charge higher prices to pay for these increasing costs," Mr Rose added.

Robert Simpson, divisional program consultant for the Addiction Research Foundation in Ontario (ARF), outlines some studies and programs developed by the ARF to set specific thresholds for drinking and for assessing high-risk behavior patterns, in a range of circumstances from the workplace to snowmobiling.

"It seems in Canada the way to drive a snowmobile is with one hand on the accelerator and a beer in the other hand."

There should be an attempt to increase understanding of what behaviors produce what results. People should believe "it can happen to them." But, they must not be misled, as in the US slogan —"Friends don't let friends drive drunk."

Mr Simpson says first someone has to define what "drunk" means. Second, once it is defined, it probably goes far beyond the risk threshold. It is impaired driving, not drunk-driving, that one should worry about, and impairment can start at a 0.02% blood alcohol concentration.

"If people think they are safe if they are not drunk, you really are not accomplishing anything."

It is also important for people in the hospitality industry to ensure the environment does not give out contradictory messages.

"Any kind of consumer responsibility campaign, or program, will be totally ineffective, totally overcome, if your environment gives out the opposing messages."

Mr Simpson notes that in the past the dominant dictum about personal responsibility was that anything which happened to individuals was of their own choosing, thus their own fault.

"Over time, it became clear that environmental conditions, ranging from advertising on the micro level, through price, and on down to the macro level, or serving practices, could effectively thwart any notion of personal responsibility for vast numbers of people."

Slowly, in both Ontario and much of the US, the pendulum of responsibility has swung more toward the providers of alcohol, who now wonder if they should bear responsibility.

"Clearly, I think they should not," Mr Simpson says. "But, I think they would be well-advised to seek a point of equilibrium,

one in which they are not fighting or sabotaging efforts to establish personal responsibility but complementing it."

The ideal situation is one in which the consumers and suppliers agree on the goal of low-risk consumption.

Happy hour restrictions

Restrictions on happy hours were first passed in Massachusetts in 1984 and are under consideration in a number of other US states. "Like it or not," regulations that "affect the liquor they serve, the price they charge, the people they hire, and the profit they keep," are here to stay for outlets, says Raymond Murgia, executive vice-president of the Massachusetts Restaurant Association.

He states regulations do not prohibit happy hours: they do prohibit programs that foster over-consumption of alcohol. His association helped draft the regulations and its advice to the industry is not to view regulatory agencies as adversaries.

Many in the industry in Massachusetts consider the restrictions "have been a blessing in disguise."

Mr Murgia: "I don't know if it has reduced the number of alcohol-related accidents (in Massachusetts), but I can tell you it sure has improved the bottom line (profits). No good operator in the past wanted to get into price competition; he was forced into it."

A more polemical view of the situation was taken at the conference by Richard Berman, senior vice-president of the S&A Restaurant Corporation, Dallas, Texas, a chain with some 350 units in 33 states.

He says that US society has an "insatiable desire to fix perceived problems very quickly." Many ask "if we can put a man on the moon why can't we do X?" And, "everybody always wants to believe that all you have to do is to decide on what the solution is, suggest that it works, and magically it will.

"I am concerned that the happy hour restrictions came bubbling up from the same pot of political solutions for complex problems."

Mr Berman accuses the anti-driving-while-impaired community of not being intellectually honest with the public: the impression is given of wholesale carnage of innocent people on the highways, whereas only 17% of those killed in car crashes involving drunk drivers fit into the category of innocent victims.

The real need is to concentrate on the problems of compulsive and abusive drinking. But, there are many people who, in good conscience, believe the way to solve the drunk-driving problem is to take eyes off the problem drinker and the abusive drinker, whom all the traffic safety experts agree are at the heart of the problem.

"You will never get drunk-driving reduced to zero, and there is no such thing as a riskless society," Mr Berman added.

Sooner or later, the public will decide some of the pop solutions — "be it labelling bottles, closing down happy hours, or seeing hours (of sale) are shorter" — are failures. Then the public will decide either people who can't handle alcohol should be treated, or, in Mr Berman's opinion, "the public will tire of the issue, period."

Mr Berman said that as president of Beverage Retailers against Driving Drunk (BRADD), he supports enthusiastically DWI programs such as those in New York which focus on the problem drinker and the aim of intervention and treatment. "Unless we are willing to refocus back on that, we are going to continue to do this pop stuff."

Friedner Wittman, PhD, senior scientist at the Prevention Research Center, Berkeley, California, and co-director of a current study on server-intervention funded by the US National Institute on Alcohol Abuse and Alcoholism, says alcohol sales are among the most regulated activities in society. The real question is how far regulations should go in protecting both the customer and the hospitality industry within a competitive business.

Much long-term research now centres on attempts to establish environmental controls on drinking "in a way such that people can have a good time, but reduces car crashes, family disputes, fights, violence, parties that go sour — those things that don't have to happen. Happy-hour legislation is a form of that experimentation."

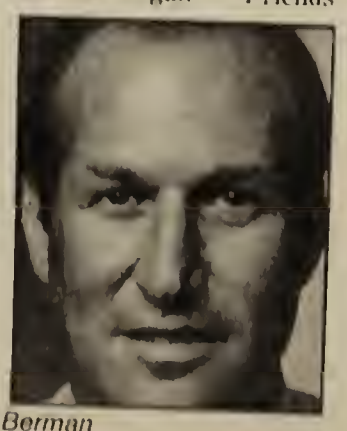
Canada and the Scandinavian countries have collected better information on general population trends than the US, although this is changing in some states where public health issues are being addressed.

Dr Wittman says cooperation by the hospitality industry with the states in setting boundaries will provide protection against lawsuits and operating losses.

The impression will be, as well, that the industry is interested in the positive use of alcoholic beverages "as part of enhancing hospitality rather than as a fail safe for generating revenue if the business isn't doing so well in other respects."

Simpson

Murgia



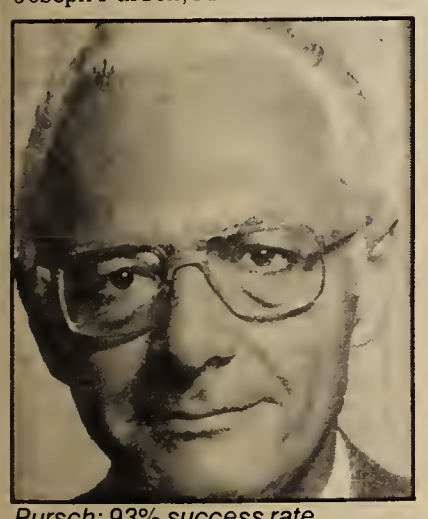
Berman

Job performance, attitudes predictors of EAP success

By Elda Hauschildt

OTTAWA — The quality of an addicted employee's job performance is the best indicator of who will recover through Employee Assistance Programs (EAPs), says a United States psychiatrist.

"I've had up to 93% success rate with alcohol and (other) drug dependent patients — provided they are sent in by an employer or are there with the concurrence of an employer, provided they have largely an alcohol dependence, and provided they do a good job," said Joseph Pursch, MD.



Pursch: 93% success rate

"Each is a good pilot, a good physician, a good radar mechanic, a good delivery truck driver, who likes his job and does it well. The company thinks he does it well and wants him back on the job.

"But, the company is also willing to say this person's job is going to be contingent on the quality of his or her sobriety. Or, if you can't recover from your alcoholism, you can no longer work here.

"With these things going for you . . . anyone can have a 93% success rate," Dr Pursch told Input 85 here, the 6th Biennial Educational Symposium on Employee Assistance Programs in the Workplace.

Dr Pursch, corporate medical director for Comprehensive Care Corporation, is a former director of the US Navy's alcohol rehabilitation service. He is special assistant on alcoholism to the US Navy surgeon general, as well as a consultant to the US Federal Aviation Administration.

The importance of EAPs, he told 500 delegates here, can be related to industrial statistics. "Every day, General Motors produces 15,000 automobiles in the United States. During that same 24-hour day, they also process 100,000 health claims, to the tune of $2.3 billion (Cdn $3.14 billion) last year."

Early identification, early treatment, and well-structured aftercare are key ingredients in EAPs, Dr Pursch suggested.

"And, personality change is by far the number one and most common indicator of when an EAP should step in. Job deterioration is way down the list; it's the last stop."

Early treatment is equally important. "We should treat these men and women within the first couple of years of decompensation, when they've been working for the bank or the company for three, or four, or five years. Then, we can have 20 years of uneventful, very productive service.

"Remember that old saying: 'he's the best man we've got when he's sober.' That's what we end up with when we treat an alcoholic — the best man when he's sober, only he's sober all the time."

The healthy employee, in turn, becomes the healthy pensioner, Dr Pursch said, a further benefit of a well-run EAP.

Input 85 was sponsored by Humber College, Toronto, in cooperation with the Canadian Addictions Foundation.

Recovering workers: the best when sober, and now sober all the time

Employee assistance makes financial sense

OTTAWA — The Royal Bank of Canada's Employee Assistance Program (EAP) is a good example of a program that works, United States psychiatrist Joseph Pursch told Input 85 here.

"The program has been running for five years and during that time 3,000 men and women have used it. These same 3,000 men and women now earn $72 million in salary and have a total of 19,000 years of banking experience among them.

"If even half of them have improved their work functioning by even 25%, the Royal Bank is recapturing $7 million per year," Dr Pursch said.

"The breakdown for this EAP is 23% referred for alcohol problems, 6% for drug problems, 24% for marital problems, and 32% for (other) emotional and mental health problems.

"Let me point out that a large number of the marital, family, and emotional problems are tied originally, subsequently, eventually, and inevitably to alcohol and drug problems."

Chinese cooking wine fad hitting Vancouver's skid row

By Heather Walker

VANCOUVER — The British Columbia government has promised local aldermen here it will look at possible controls on the sale of Chinese cooking wine, the latest alcohol substitute for the city's skid row alcoholics.

Consumer and Corporate Affairs Minister Jim Hewitt told the aldermen — at a meeting they had requested — his department is considering issuing permits to stores selling the wine. The permits could then be rescinded if police found the wine was being sold to anyone who was intoxicated.

Chinese cooking wine, containing between 35% and 37% alcohol by volume, costs from $3.50 to $4 a bottle. Police here say it is sold under the counter to alcoholics in contravention of a city by-law.

Police Sergeant Max Chalmers told city council's community issues committee at least three stores in the skid row area sell large quantities of two varieties of locally-produced cooking wine.

In several incidents, the wine was sold to men he described as "obviously intoxicated." The police investigation uncovered large quantities of wine kept under sales counters, and stored in cases, Sgt Chalmers said.

Sue Harris, community worker with the Downtown Eastside Residents' Association, said her group is concerned about the wine's high salt content. (It contains 1.5% salt to meet legal requirements allowing it to be sold as a cooking product exempt from control by the provincial liquor board.)

Ms Harris: "The salt is supposed to make it not potable, but it clearly is potable," she told **The Journal**. She added the salt is hazardous to people with heart conditions, beyond the danger of the wine's high alcohol content.

"We get complaints about this stuff virtually every day," Ms Harris said. "It's a problem because it isn't controlled. The provincial government should be controlling any alcohol product. People say they don't sell it, but . . . there are empties everywhere you look. It's coming from somewhere."

Study links smoking with cervical cancer

By Harvey McConnell

WASHINGTON — A significant increase in activity in cervical mucus among female smokers has been shown in a San Francisco pilot study.

Elizabeth Holly, PhD, University of California, San Francisco's Northern California Cancer Program, said the findings lend support to other studies which have shown the ability to measure products of cigarette smoke and their metabolites in body fluids distant from the initial uptake site.

She told the American Public Health Association here that in recent years several studies have reported an association between cigarette smoking and cancer of the uterine cervix, even after adjustment for known risk factors, including the number of sexual partners and age of first intercourse.

Dr Holly said the San Francisco study involved 36 women who were cigarette smokers and 42 who were non-smokers, all between 20 and 49 years of age, and all of whom had cytologic smears at university clinics or a physician's office.

Smokers smoked at least one pack of cigarettes a week. The Ames and Salmonella microsomal tests for mutagenicity were used for cervical fluid.

Dr Holly said there were no statistical differences between the smokers and non-smokers on current medication and vitamin use, number of days since last sexual intercourse, current method of contraception, gynecological diagnosis on the day the specimen was obtained, and number of days since the last menstrual period.

The only difference was in age: a median 28 years for smokers and 31.9 years for non-smokers.

The researchers found that 14 (39%) of the smokers and five (12%) of the non-smokers had mutagen-positive cervical fluids. While some of the positive results could have been caused by mutagens in the diet, smokers and non-smokers should not have been affected differently by diet alone, said Dr Holly.

NEWS

Alcoholic ataxia not dose-dependent

CHICAGO — Moderate drinking does not appear to protect alcoholics from developing cerebellar degeneration, says a San Francisco study.

"Our study suggests alcoholic cerebellar degeneration is not a dose-dependent phenomenon," William Estrin, MD, assistant professor of neurology, University of California School of Medicine, said here at the annual meeting of the American Neurological Association.

"Instead, it might be that alcoholics who develop cerebellar degeneration are the ones who are especially sensitive to the neuronal effects of alcohol — even alcohol in relatively small doses."

Dr Estrin says there is widespread belief among clinicians and researchers working with alcoholics that cerebellar degeneration occurs in individuals who drink most heavily. But, no one has ever satisfactorily explained why some extremely heavy drinkers can drink for years without showing any signs of ataxia. Also a mystery is the fact that some alcoholics who drink relatively little develop severe degeneration of the cerebellum.

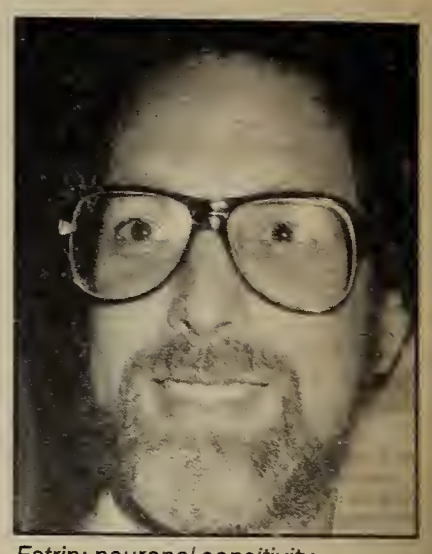
To study their hypothesis that the development of alcoholic cerebellar degeneration does not depend on the amount of alcohol taken, Dr Estrin and associates conducted a case-control study.

Eleven alcoholics with clinical evidence of cerebellar degeneration — eight had computed tomographic confirmation of cerebral atrophy — were matched by age, sex, and race to a control alcoholic with no evidence of cerebellar degeneration and also to a control non-alcoholic. The alcoholic subjects were undergoing treatment at the San Francisco Alcohol Clinic.

All study subjects received a full neurological examination and a battery of laboratory tests. A questionnaire designed to detect biases in reporting was administered to determine daily and lifetime alcohol, caffeine, and cigarette consumption.

"Surprisingly, there was about a 30% lower daily alcohol consumption in ataxic alcoholics and about a 50% lower maximal lifetime consumption," Dr Estrin said. "This gives some strength to our hypothesis that the alcoholics who get ataxia and develop cerebellar degeneration aren't necessarily the ones who drink more.

"Perhaps one explanation could be that after an alcoholic becomes ataxic, he can't find his way to get his alcohol. But, we looked at maximal lifetime consumption so it's not likely that was the case. There might have been some acute nutritional event, such as Wernicke's encephalopathy, which a lot of people believe to be the cause of ataxia. But, the best explanation is that there is something peculiar about the ataxic alcoholic — perhaps a genetic predisposition, an unusual sensitivity to the neuronal effects of alcohol, or some other intrinsic factor that makes them more likely to develop ataxia.



Estrin: neuronal sensitivity

"Basically, our study points to a need to look for more specific metabolic abnormalities among the sub-population of alcoholics who develop ataxia," Dr Estrin said. "It's very important to identify the people who are at most risk because then we might be able to make appropriate interventions to prevent cerebellar degeneration."

Dr Estrin said that cerebellar degeneration is turning out to be a much more complex phenomenon than previously thought — in the same way that cirrhosis also does not appear to be a dose-dependent phenomenon, but one that appears to involve an as yet unidentified intrinsic or extrinsic factor.

'Residual goodwill' aids resolution

Sex problems can arise in alcohol recovery

By Peter Unwin

BALTIMORE — Recovery from alcoholism not only does not guarantee improved sexual or intimate relationships, it may also bring new and serious sexual problems, suggests a study by three researchers at the Sexual Behaviors Consultation Unit, Johns Hopkins School of Medicine, here.

The project involved a 12-year study of 24 couples — one or both partners recovering alcoholics — who presented for treatment of sexual problems appearing to develop after sobriety.

Included were 18 couples with alcoholic husbands sober from two to eight years for whom drinking had "seriously impaired social, vocational, and marital functioning."

The husbands saw little or no connection between their drinking behaviors and their partner's sexual satisfaction. Wives, however, "were acutely aware of the relationship between their level of satisfaction and their husband's drinking," and frequently reported "feeling repulsed" by sex with drunken husbands.

Following sobriety, these husbands developed an "intense commitment to Alcoholics Anonymous," viewed alcoholism as a "disease," and shared with their wives "the absolute belief that the cessation of drinking had stabilized their marriages."

However, both husbands and wives felt "sexual dysfunction and emotional estrangement" distressing enough to cause them to seek treatment. None from this group attending therapy considered they had a serious sexual problem until sobriety was achieved.

In a second study group of four couples with a long history of dual drinking and abuse of street drugs, the researchers found both partners agreed that alcohol or other drugs made them less sexually inhibited. Wives, however, viewed their sexual experience in a more negative, ambivalent way, compared to their husbands who tended to idealize it.

A third group consisted of two couples in which the wives were recovering alcoholics and the husbands non-drinkers. Both wives and husbands complained about the poor quality of their marital and sexual lives. The husbands, however, saw the problem in terms of the wives' weakness and refused to enter conjoint therapy.

Of the 18 couples with recovering alcoholic husbands, nine dropped out of treatment after two to four months. Those reporting improvement, says the study, were couples with enough "residual goodwill and affection to bring their anger and hostility into reasonable control."

Pulpit messages

LONDON — A doctor here has called on the clergy and churchgoers to give up smoking. Alan Sheard has challenged ministers to preach the message that "health is a most precious gift of God," says *The Medical Post*. Dr Sheard says that despite the danger of smoking, he has yet "to hear this evil condemned from the pulpit."

DEPARTMENT

New Books

by MARGY CHAN

Studies of Drinking in Public Places: An Annotated Bibliography

. . . by Honey R. Fisher

This bibliography pulls together a list of publications on public drinking that are dispersed in the social science literature. The 151 annotated citations cover the nature and function of different drinking establishments, the characteristics of patrons, situational influences on drinking behavior, and problems associated with drinking in public places. It is an international collection comprised of research studies, historical studies, review articles, and theoretical papers written between 1897 and 1984. The bibliography will be a very useful resource for researchers in the field as well as policy makers, in terms of its examination of legal liability, availability, preventive measures, and environmental design.

Marketing Services, Addiction Research Foundation, 33 Russell St, Toronto, Ontario. 1985. (ARF bibliographic series No 18.) 85 p. $15. ISBN 0-88868-106-2

Fetal Alcohol Exposure and Effects: A Comprehensive Bibliography

. . . by Ernest Abel

The author published a related bibliography, *Alcohol and Reproduction*, in 1982. This latest work focuses on pregnancy and fetal development, including sperm production and ovulation. The 1982 book dealt with alcohol's effects on sexual behavior, function, and physiology. Together, the two bibliographies represent the most comprehensive listing of publications on alcohol's effects on reproduction.

The new bibliography is arranged in alphabetical order, by author, with entries retrievable from a subject index.

Greenwood Press, Westport, CT. 1985. 309 p. $45. ISBN 0-313-246327

Children of Alcoholics: A Review of the Literature

. . . by Marcia Russell, Cynthia Henderson, and Sheila B. Blume

It is estimated that one out of every eight United States citizens are children of alcoholic parents. This is an area of increasing concern not only because of the number of people thus at high risk of alcoholism, but also because of emerging evidence of other medical, emotional, and social problems caused in children by parental alcoholism. This comprehensive review of the literature served as the basic reference document for discussions in the research conference organized by the Children of Alcoholics Foundation in April, 1984. The book summarizes current knowledge and identifies important leads and gaps. Each section focuses on a specific aspect of the problem. A list of bibliographic references is provided.

Children of Alcoholics Foundation, Inc, 23rd floor, 540 Madison Ave, New York, NY 10022. 1985. 68 p.

Cocaine: A Selection of Annotated Papers from 1880 to 1984 Concerning Health Effects

. . . by Lise Anglin

This annotated bibliography, a selection of 277 papers from 600 items on cocaine collected by Ontario's Addiction Research Foundation, provides a good overview of the important cocaine literature dealing with health effects of recreational use.

Most of the papers have appeared in scientific journals, but several have been published as book chapters or separate reports. The annotations are non-evaluative. Each citation includes a list of key words representing concepts discussed in the paper. Both the key words and the detailed subject index assist readers in finding specific topics with precision and speed. The book is a handy reference tool for all workers in the addictions field.

Marketing Services, Addiction Research Foundation, 33 Russell St, Toronto, Ontario. 1985. (ARF bibliographic series No 19.) 223 p. $20. ISBN 0-88868-114-3

Other Books

Cocaine Use in America: Epidemiologic and Clinical Perspectives — Nicholas J. Kozel, and Edgar H. Adams (eds). 1985. This monograph is based on papers presented at a technical review of patterns of cocaine use in the United States, July 11-13, 1984, at Bethesda, Maryland. National Institute on Drug Abuse research monograph No 61, Rockville, MD. 226p. DHHS Publication No (ADM) 85-1414.

Prenatal Drug Exposure: Kinetics and Dynamics — C. Nora Chang, and Charles C. Lee. 1985. Animal models for study of fetal drug exposure; biotransformation of drugs and foreign chemicals in the human fetal-placental unit; pharmacokinetics of drugs and metabolites in the maternal-placental-fetal unit; the pharmacodynamics of prenatal chemical exposure; opioids and development; pharmacodynamics of fetal exposure to narcotics; positron-emission tomography; placental transfer of drugs, alcohol, and components of cigarette smoke and their effects on the human fetus. National Institute on Drug Abuse research monograph No 60. 147p. DHHS Publication No (ADM) 85-1413.

Alliance for Change: A Plan for Community Action on Adolescent Drug Abuse — James F. Crowley. 1984. This book is divided into two parts. Part one describes the futile approaches used by adults to "solve" the adolescent drug problem, barriers to action, and the process of community mobilization to set up school-based early-intervention programs. Part two recounts how people in Ohio and Montana have joined forces to make changes in their communities. It also offers personal accounts of individuals who have worked to change their own systems. Community Intervention Inc, 529 S 7th St, Ste 470, Minneapolis, Minnesota 55415. 222p. ISBN 0-9613416.

Under Fire: A History of Tobacco Smoking in Australia — Robin Walker. This book provides a concise historical explanation of a contemporary social issue. Melbourne University Press, Carlton, Victoria 3053. 155p. $22.25. ISBN 0-522-842798.

Problem Drinking: Experiments in Detoxification — Report of the Detoxification Evaluation Project. 1985. This is the first full-scale study of detoxification services in Great Britain. It describes and compares five examples of detoxification services and covers both practical and policy matters. Bedford Square Press of the National Council for Voluntary Organizations, 26 Bedford Square, London, WC1B 3HU. 177p. $12.95. ISBN 0-7199-1115X.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Reason to Live

Number: 719.
Subject heading: Impaired driving.
Details: 25 min.
Synopsis: Sergeant Jack Ware, a breath-test analyst, gives a lecture on the dangers of drinking and driving. He relates his experience while participating in a training course. He and his fellow officers were given a quantity of alcohol and tested on a breath analysis machine. Sgt Ware felt only slightly intoxicated at a blood alcohol level (BAL) of 0.06%, yet a non-drinking colleague with a similar BAL could barely stand. Since everyone reacts differently to alcohol, it is important to be aware of one's own sensitivity. Sgt Ware advises people not to drink and drive, even if below the legal blood-alcohol limit.
General evaluation: Poor (2.1). The example of differences in tolerance is well presented; however, other information is confusing or unrealistic. For example, Sgt Ware first says never get into a car with an intoxicated driver; later he advises to get in, distract the driver, grab the keys, and throw them out.
Recommended use: None.

Lori — Recovery Series

Number: 720.
Subject heading: Women and alcohol: treatment/rehabilitation.
Details: 14 min.
Synopsis: Lori, a lesbian, is interviewed about her past drinking and her treatment. She says she drank "alcoholically" right from the first. After many years, she admitted herself to a psychiatric ward. There she suffered such severe withdrawal that she realized she needed more treatment. At a women's treatment centre, she learned how to restructure her life and has now been sober for five years.
General evaluation: Good to very good (4.7). This film (one of a series of four) provides good insight into the treatment process. It is believable and judged a good teaching aid.
Recommended use: With a resource person, this film could benefit women either contemplating treatment or already in treatment. It would also be useful for health professionals.

Delia — Recovery Series

Number: 721.
Subject heading: Women and alcohol: treatment/rehabilitation.
Details: 12 min.
Synopsis: Delia is a health-care professional and a single parent. She always believed it was necessary to achieve. She drank a great deal, even when treating others for alcohol problems. Her friends finally persuaded her to get help herself. Although she has completed a treatment program, she is still having difficulty and is not yet working full-time.
General evaluation: Good (4.1). This film, in the "Recovery Series," contains good information about many problems faced by single parents, and realistically portrays someone who has been "dry" for only 15 weeks.
Recommended use: With a resource person, this film could benefit women contemplating treatment, or already in treatment. It would also be useful for health professionals.

Ruth — Recovery Series

Number: 722.
Subject heading: Women and drugs: treatment/rehabilitation.
Details: 14 min.
Synopsis: Ruth has used heroin, alcohol, and prescription drugs. She worked the streets to pay for her habits. She tried to get off drugs on her own and suffered severe withdrawal.
General evaluation: Very good (5.0). This film, one of the "Recovery Series," realistically portrays the lifestyle and recovery of a drug abuser. It stresses the need to take responsibility for one's recovery.
Recommended use: With a resource person, this film would benefit health professionals and women in treatment.

Debby and Sharon — Recovery Series

Number: 723.
Subject heading: Native people — women and alcohol: treatment/rehabilitation.
Details: 15 min.
Synopsis: Debby and Sharon are sisters who grew up in an alcoholic family, have had problems with alcohol themselves, and, as a result, have had problems with their own families. Both have been sober for awhile and are now taking a greater interest in their Native culture, learning to be proud of their heritage.
General evaluation: Good to very good (4.9). This film, one of the "Recovery Series," gives a good perspective on the problems that some Native women face and could encourage others to seek treatment.
Recommended use: With a resource person, this film could benefit women in treatment, or contemplating treatment.

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Canadian Society of Hospital Pharmacists 17th Annual Professional Practice Conference — Feb 3-5, Toronto, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

The Street is No Place for a Kid: Symposium on Street Youth — Feb 10-12, Toronto, Ontario. Information: 1st Annual Symposium on Street Youth, Covenant House, 70 Gerrard St E, Toronto, ON M5B 1G6.

Ontario Psychological Association Annual Meeting — Feb 13-15, Toronto, Ontario. Information: Mona Abbott-Kesting, administrative officer, OPA, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

Health Promotion Workshop —Feb 24-26, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Association of Addiction Counsellors 7th Annual Conference: Families of Alcoholics — March 8, Toronto, Ontario. Information: Kathryn Irwin, conference chairperson, 3253 Bathurst St, #B3, Toronto, ON M6A 2B4.

National Consultation on Women and Drugs — May 12-15, Geneva Park, Ontario. Information: K. Madden, health promotion directorate, Health and Welfare Canada, Rm 449, Jeanne Mance Bldg, Tunney's Pasture, Ottawa, ON K1A 1B4.

Youth and Drugs, PRIDE CANADA Conference — May 22-24, Saskatoon, Saskatchewan. Information: Eloise E. Opheim, PRIDE CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Ontario Association of Professional Social Workers Annual General Meeting and Provincial Conference — May 29-31, Waterloo, Ontario. Information: OAPSW, 410 Jarvis St, Toronto, ON M4Y 2G6.

Ontario Medical Association 106th Annual Meeting — June 9-12, Toronto, Ontario. Information: annual meeting coordinator, OMA, 250 Bloor St E, Ste 600, Toronto, ON M4W 3P8.

77th Annual Conference of the Canadian Public Health Association — Health Promotion Strategies for Action — June 16-19, Vancouver, British Columbia. Information: CPHA, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

27th Annual Institute on Addiction Studies — July 13-18, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School for Addiction Studies — July 14-15, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Dynamics of Social Change: Implications for Safety — July 29-Aug 1, Edmonton, Alberta. Information: Herb M. Simpson, Traffic Injury Research Foundation of Canada, 171 Nepean St, Ste 600, Ottawa, Ontario K2P 0B4.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

Social Services Federation of Canada: Research 86 — Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario, K1A 0N5.

United States

The Images Within: A Child's View of Parental Alcoholism — Feb 19-March 5, San Francisco, California. Information: Children of Alcoholics Foundation, Inc, 23rd Fl, 540 Madison Ave, New York, NY 10022.

2nd Annual National Convention on Children of Alcoholics — Feb 23-27, Washington, DC. Information: US Journal of Drug and Alcohol Dependence, Inc, national convention coordinator, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

International Congress and Exposition — Alcohol, Accidents, and Injuries — Feb 24-28, Detroit, Michigan. Information: National Highway Traffic Safety Association, 400 7th St SW, Washington, DC 20591.

American Medical Writers Association 7th Western Regional Conference — March 9-13, Pacific Grove, California. Information: American Medical Writers Association, 5272 River Rd, Ste 410, Bethesda, Maryland 20816.

Substance Abuse Seminar — A National Problem: Prevention and Rehabilitation — March 12, New York, NY. Information: Association for Children with Learning Disabilities 1986 Conference, 4156 Library Rd, Pittsburgh, Pennsylvania 15234.

American Pharmaceutical Association — March 15-20, San Francisco, California. Information: American Pharmaceutical Association, 2215 Constitution Ave, NW, Washington, DC 20037.

PRIDE 1986 International Conference on Drugs — March 18-22, Atlanta, Georgia. Information: PRIDE (National Parents' Resource Institute for Drug Education, Inc), 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

SECAD-West — Current Trends in Addiction — April 3-6, Denver, Colorado. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, Addictive Disease Division, 11050 Crabapple Rd, Ste D-120, Roswell, Georgia 30075.

American Medical Association 7th National Conference on the Impaired Physician — April 10-13, Chicago, Illinois. Information: American Medical Association, 535 N Dearborn St, Chicago, IL 60657.

NCA Annual Conference — April 18-21, San Francisco, California. Information: National Council on Alcoholism, 12 W 21 St, New York, NY 10010.

American Medical Society on Alcoholism and Other Drug Dependencies and the Research Society on Alcoholism — Joint Meeting — April 18-22, San Francisco, California. Information: AMSAODD-RSA Meeting, 12 W 21st St, New York, NY 10010.

3rd National Conference on Alcohol and Drug Abuse Issues in Higher Education — April 27-29, San Antonio, Texas. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St NW, #181, Washington, DC 20001.

NECAD 86 — May 4-7, Newport, Rhode Island. Information: Jane Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Rd, Newport, RI 02840.

American Psychiatric Association Annual Meeting — May 10-16, Washington, DC. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

1986 National Association of Social Workers National Conference on Women's Issues — Dangers and Opportunities: What's Ahead for Women? — May 28-31, Atlanta, Georgia. Information: NASW conference planning committee, 7981 Eastern Ave, Silver Spring, Maryland 20910.

International Drug Development in the 21st Century — 22nd Annual Meeting, Drug Information Association — June 1-5, Washington, DC. Information: Drug Information Association, PO Box 113, Maple Glen, Pennsylvania 19002.

American Society of Hospital Pharmacists — June 1-5, Denver, Colorado. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

48th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 16-18, Tahoe City, California. Information: Mary Jeanne Kreek, Committee on Problems of Drug Dependence, Inc, The Rockefeller University, 1230 York Ave, New York, NY 10021.

37th Annual Symposium on Alcoholism — June 16-27, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

17th Annual Narcotic Research Conference — July 6-11, San Francisco, California. Information: E.L. Way, dept of pharmacology, University of California, San Francisco, CA 94143.

North American Congress on Alcohol and Drug Problems — Sept 7-11, Boston, Massachusetts. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St NW, #181, Washington, DC 20001.

Association of Labor-Management Administrators and Consultants on Alcoholism — Nov 1-5, Dallas, Texas. Information: ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

American Association for Advancement of Behavior Therapy Annual Meeting — Nov 13-16, Chicago, Illinois. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

Abroad

Seminar on Addiction — March 1-9, London, England. Information: Agency International Inc, 303 Maple Dr NE, Atlanta, Georgia 30305.

15th International Institute on the Prevention and Treatment of Drug Dependence — April 6-11, Amsterdam/Noordwijkerhout, The Netherlands. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

2nd Annual International Industrial Alcoholism Symposium — May 20-22, Frankfurt, Germany. Information: Annette Stappert, conference coordinator, Conecta, 12 Stooter St, 4330 Mulheim 13, Germany.

32nd International Institute on the Prevention and Treatment of Alcoholism — June 1-6, Budapest, Hungary. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

3rd Congress of the International Society for Biomedical Research on Alcoholism — June 8-13, Helsinki, Finland. Information: Sari Salo, 3rd ISBRA Congress, Alko Ltd, PO Box 350, SF00101, Helsinki, Finland.

International Symposium on Health Education in Schools —July 6-10, Jerusalem, Israel. Information: D. Tamir, International Symposium, PO Box 394, Tel Aviv 61003 Israel.

International Sociological Association World Congress — August 13-18, New Delhi, India. Information: Alex C. Michalos, University of Guelph, Guelph, Ontario, N1G 2W1.

14th International Cancer Congress — Aug 21-27, Budapest, Hungary. Information: Crimson Travel Service, 39 John F. Kennedy St, Cambridge, Massachusetts 02138.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

10th International Conference on Alcohol, Drugs and Traffic Safety — Sept 9-12, Amsterdam, The Netherlands. Information: Symposium Secretariat, QLT, Convention Services, Keizersgraacht 792, NL-1017 EC Amsterdam.

International Symposium on Young Drivers' Alcohol and Drug Impairment: Selective Countermeasure Program Development — Sept 13-15, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, dept of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

Vol. 15 No. 1 — TORONTO, January 1, 1986

The Journal

1986 CALENDAR The centre section

Underground laboratories were the catalyst

Futureshock drugs will defy current concepts

By Anne MacLennen

Ex-addict athletes rarely regain 'edge'

Cigarette smoke now implicated in sudden infant death syndrome

Mila bows out

INSIDE

Ontario bolsters treatment funding p2

IV drug users respond to AIDS scare p3

Drug courses take to the air p4

NS docs want peer review first p6

Kids getting wise to Marlboro Man

The Back Page

Keep in touch!

subscribe

Canada	$16/yr
USA & Foreign	$24/yr
Microfiche	$18/yr
Air Mail	add $19/yr

(Please prepay)

The Journal, Marketing Services, Addiction Research Foundation Dept KMM, 33 Russell Street, Toronto, Canada M5S 2S1.

Name _____

Address _____

_____

RCMP National Drug Intelligence Estimate

Drugs international: the market that is Canada

Maplines

The just-released 1984/85 Royal Canadian Mounted Police (RCMP) National Drug Intelligence Estimate *provides a comprehensive review, from an enforcement perspective, of the origin, volume, trafficking routes, modes of transport, and smuggling of all drugs on the illicit market in Canada. (1984/85 is the year for which most-recent, complete figures are available.)*

While the review analyzes significant drug trade developments, intelligence estimates are based on often limited statistical data. The report's authors from the Strategic Analysis and Publications Section, Headquarters, Drug Enforcement Directorate, Ottawa caution "that intelligence-gathering with respect to production, traffic, and use of illicit drugs poses special problems, particularly where quantitative estimates are concerned . . . . Therefore, statistical methods which may yield only approximate estimates must often be used."

The summary of the 1984/85 estimates has been condensed below as a service to readers of The Journal.

Heroin

Approximately 820 tons of opium were produced in 1984 in Southeast Asia's Golden Triangle where the borders of Thailand, Burma, and Laos meet.

This region supplied Canada with about two-thirds of its heroin in that year. There are now several new routes which traffickers have used to move narcotics from northern Thailand, either to Bangkok or out of the country. These routes were established because Thai authorities have stepped up enforcement along the traditional direct route into Bangkok.

Malaysia's close links with southern Thailand, its smuggling history, its Chinese community with international connections, and good communications, make the country a staging area for heroin produced in the Golden Triangle and destined for North America and Europe.

Southwest Asia, comprised of sections of Pakistan, Afghanistan, and Iran, was the source of about one-third of Canada's heroin in 1984 — producing about 580 tons to 950 tons of opium. Although the Soviet Union has been used as a trans-shipment area for narcotics travelling between northwestern Afghanistan and northeastern Iran, the primary routes used to smuggle narcotics into Iran remain through the Baluchistan area of Pakistan/Iran as well as the Khorasan, Iran/Afghanistan border.

India is still a transit country for Southwest Asian opiates destined for Canada, the United States, and Europe. The drugs are routed primarily via land, across the border between Pakistan and India.

While Mexican heroin supplies comprised only a negligible portion of Canada's illicit market, it is potentially a major source of the drug to Canada.

Heroin availability fluctuated throughout Canada; however, the retail price and purity index suggest a slight increase in the supply of the narcotic, particularly in eastern Canada. This contrasts with the decrease in the number of people charged with narcotic-related offences in 1984 compared to 1983.

A supporting factor, however, for the perceived increase in supply is the rise in the amount of heroin seized, a figure which rose by approximately 30% from 1983.

The majority of available heroin was found in Vancouver, Toronto, and Montreal, smuggled in through their international airports.

Cocaine

RCMP Drug Intelligence coordinators in all domestic drug regions of Canada reported cocaine could be purchased readily in major metropolitan areas, as well as in smaller and more remote communities. This expansion of the cocaine market, which had been predicted in the 1983 estimates, was confirmed by 1984 increases in cocaine seizures, people-charged statistics, and average purities at the wholesale and retail levels.

In 1984, 115 kilograms of cocaine were seized across Canada, an increase of 17% over 1983.

In relation to cocaine possession, trafficking, and importation, 1,161 people were charged, a 13% increase from 1983.

The cocaine market is expected to continue to be active despite major seizures and disruptions recorded in South America. Coordinated and renewed drug enforcement efforts in the southern hemisphere may encourage traffickers to extend and relocate their activities in areas surrounding Peru, Bolivia, and Colombia to circumvent crop substitution, eradication, and other interdiction measures. Vigorous international measures may bring about a stabilization of this illicit market after the rapid expansion recorded in the early 1980s.

RCMP statistical data demonstrate a dramatic reversal in the distribution of market shares held by South American trafficking organizations from previously established patterns, which underlined Colombia's dominance of the international cocaine trade. Under measures imposed by Colombia's government targeting cultivation, processing, and distribution, Colombian traffickers were replaced by Bolivians as the principal suppliers of cocaine to Canada.

Bolivia now accounts for an estimated 32% of the market, slightly ahead of Peru with 31%. Other South American source countries, including Brazil, increased their share to 19%, while Colombia supplied only 18% of the market. Colombia's dominance of the cocaine trade, a trend noted since the early 1980s, has been disrupted. This development indicates the dynamic nature of the illicit cocaine market.

There has been significant shift in the modes of transportation used to smuggle cocaine into Canada. In 1984, 57% of seizure incidents identified air transportation as the method of entry. Land conveyance followed with an estimated 40%, while maritime incidents were 3%.

Generally stable prices, with only slight decreases at both wholesale and retail levels from 1983 figures, were recorded in the major metropolitan centres of Canada. Retail purity levels were moderately higher than those recorded in 1983.

Montreal figured prominently in Canada's cocaine market, serving as the leading national distribution centre while doubling as a regional distribution point serving eastern Canada. It was also the location of a cocaine-processing laboratory seized in 1984.

Chemical drugs

International authorities have warned chemical drugs such as amphetamines and barbiturates are being abused increasingly to an extent probably greater than commonly assumed.

The principal sources of chemical drugs available in Canada's illicit drug market remained domestic clandestine laboratories, illegal importation of illicitly-manufactured and diverted drugs from foreign sources, and diversion of drugs legally manufactured in Canada.

The most frequently abused Schedule G (controlled) drugs of abuse were methamphetamine (Desoxyn), amphetamine (Benzedrine), secobarbital (Seconal), Amobarbital (Amytal), methaqualone (Quaalude), and methylphenidate (Ritalin). LSD, MDA, and psilocybin remained the most commonly-abused Schedule H (restricted) drugs. Diazepam (Valium), flurazepam (Dalmane), and chlordiazepoxide (Librium) were the most commonly-encountered Schedule F (prescription) drugs being abused.

The most popular illicit chemical drug of abuse was LSD.

The continuing demand for drugs of abuse, together with the enormous profits which are available from their sale, have made the manufacture and traffic of look-alike and act-alike substances an extremely lucrative business. This includes so-called "designer drugs" like alpha-methyl fentanyl, known to the drug-abusing community in the US as China White (The Journal, January). There is a growing number of products promoted as cocaine substitutes on the Canadian market.

The greatest portion of chemical drugs consumed in Canada are domestically-produced with the exception of LSD and the look-alike and act-alike drugs, which are generally produced in the US.

Canada remains a source for diazepam which is being used to produce counterfeit methaqualone tablets destined for resale in the US.

As has been the case in recent years, the principal organizations involved in financing, manufacture, and distribution of chemical drugs are outlaw motorcycle gangs.

Cannabis

Cannabis derivatives (marijuana, hashish, and liquid hashish) were again the most readily available drugs of abuse in Canada (a trend noted since the publication of the first estimate in 1982). These drugs were prevalent in all domestic drug regions of the country.

Marijuana seizures dropped significantly to 3,844 kilograms in 1984 from 23,361 kg in 1983: Hashish removals declined 31% to 2,379 kg in 1984 from 3,467 kg in 1983. Liquid hashish is the only cannabis derivative to have recorded an upward move — to 208 kg in 1984 from 185 kg in 1983 (a 12% increase).

Total cannabis seizure statistics are 76% lower than 1983 figures. This dramatic decrease can be explained by the emphasis placed by the RCMP on heroin and cocaine, higher-level targetting, the redeployment of drug enforcement personnel, and because no "mothership" operations were seized during the year under review.

The general decrease in cannabis seizures was also reflected in the number of people charged with related offences. Declines in possession and trafficking charges were not offset by the marginal increases in importation and cultivation charges. Figures for people charged with cannabis-related offences were 15% lower than those recorded in 1983.

Several countries supplied cannabis products. Colombia has a leading role as the primary foreign producer of marijuana reaching Canada. Colombia's market share has, however, dropped because of increased law enforcement there.

Thailand, Jamaica, Mexico, the US, and Canada itself, also supplied the illicit marijuana market. This is the first time Mexico and the US have been identified individually as marijuana suppliers to the Canadian market.

The hashish market was supplied by three principal foreign sources: Lebanon, Pakistan/India, and Jamaica. The liquid hashish portion of the cannabis market was again dominated by Jamaica.

Marijuana was smuggled into Canada by various transportation means. Air and sea conveyance each accounted for an estimated 40%, with the remaining 20% entering the domestic market via land. Hashish was smuggled into Canada primarily by sea, accounting for an estimated 94%.

THE BACK PAGE

Canada's new DWI laws — one step forward

By Joan Hollobon

TORONTO — Federal legislation, effective in Canada last December, raising minimum penalties for drinking and driving will exert its greatest influence in the long run through its message that drinking and driving is unacceptable.

Robert M. Solomon, professor in the faculty of law at the University of Western Ontario (UWO) and author of the book *Drug and Alcohol Law for Canadians*, backs up his statement that "drinking and driving is by far the largest single criminal cause of death in Canada" with statistics on deaths and injuries in accidents including drinking. (See The Back Page.)

Experts consulted by **The Journal** are unanimous in agreeing with Mr Solomon that while the new legislation is a "useful step forward," it is not a panacea and alone will not solve the problem.

"But, it focuses public attention. It gets the message across that this is of great concern, that there is too much carnage on the highways, and that drinking and driving is truly a criminal problem, beyond a social problem," said Murray Segal, senior counsel in Ontario's Ministry of the Attorney General.

Eric Single, PhD, senior scientist, the Addiction Research Foundation (ARF) here, said: "The law has an educational effect; it reinforces cultural values and norms .... The moral pressure from drinking peers and confederates is much stronger than the law."

The stiffer penalties have been welcomed cautiously but with reservations.

"The likelihood of apprehension is a greater deterrent than an increase in the penalty," said Paul Whitehead, PhD, professor, department of sociology, UWO.

Evelyn Vingilis, PhD, head, drinking driving research program, ARF, put it a little differently: "How long the deterrent

(See DWI, p2)

Solomon

Single

Vingilis

Vol. 15 No. 3 2nd Class Mail Reg No. 2776 TORONTO, March 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Urine testing issues clouded: Dogoloff

By Harvey McConnell

WASHINGTON — Mysteries about urine testing for alcohol and other drugs need to be dispelled for both the general public and industry. These include the science involved, legal issues, and issues of individual rights.

"And, we need to get rid of a lot of leftover baggage from the 1960s — that it is okay to do with your body what you will; drug taking is a victimless crime — as well as the erroneous, knee-jerk reaction that one dirty urine means somebody will be canned," declares Lee Dogoloff, executive director of the American Council on Drug Education here.

He told **The Journal** testing urine for alcohol and other drugs is growing in both business and sports, and as long as the US has high drug use rates among its population, screening is not going to abate.

The real issues are not weighing public safety and public confidence against the individual's right to abuse his or her body with drugs; the issues are maintaining a safe work place and insuring public safety, he said.

"It is not a moral issue. It is not an issue on the basis of not wanting people to have fun and use drugs. It is an issue involving concrete things."

Mr Dogoloff believes misinformation is being tossed about by people who, for a variety of reasons, oppose urine testing for drugs.

"One of the biggest red herrings is that testing isn't good enough, it isn't reliable enough. Well, it is reliable if it is done well and if you have alternative technology to repeat the testing."

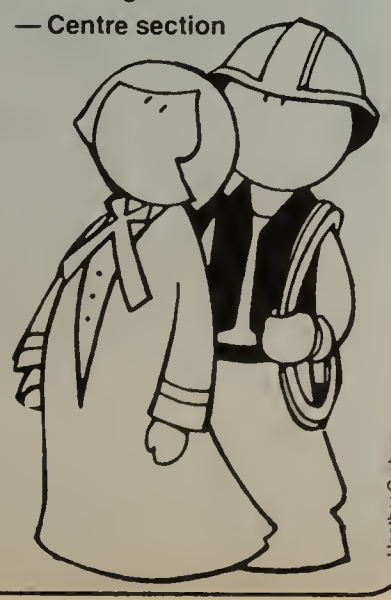
Mr Dogoloff, who was head of the White House Office on Drug Abuse Policy under President Jimmy Carter, remarked on the

(See Urine, p2)

Rights and responsibilities

The ethics of urine screening

— Centre section



Heather Graham

'Wave of support' at UN meeting

New drug treaty backed

Anne MacLennan reports

VIENNA — A new international treaty against traffic in narcotic and illicit psychotropic drugs has been given the go-ahead here at the February meeting of the United Nations Commission on Narcotic Drugs.

The convention — the third major international treaty against narcotics (**The Journal**, July, 1985) — is being designed to boost significantly international enforcement powers against illicit drug traffic and traffickers.

The initiative for a third treaty came formally to the commission last year from the UN General Assembly, through the Economic and Social Council.

Although many governments and experts still consider the two existing major treaties adequate and in fact suggest they might better be amalgamated into one, more comprehensive treaty, government after government at the meeting this year said it would not stand in the way of the apparent "wave of support" for the new convention.

Elements proposed for the convention include tracing, freezing, and forfeiture of the proceeds of trafficking; extradition for drug trafficking; monitoring control of specific chemicals and precursors of drugs liable to abuse; checking on illicit traffic via commercial carriers; controlled delivery; fighting smuggling of drugs through the mails; denial of passports or travel documents to convicted drug traffickers; and, measures against drug traffic on the high seas.

Most governments particularly emphasized the need for provisions in the convention concerning the tracing, seizing, and forfeiture of proceeds of trafficking, and for "meaningful provisions" on extradition procedures for traffickers.

They reiterated that the new convention should not duplicate the provisions of existing international drug control treaties, and that provisions should be formulated so the greatest number of states will be in a position to ratify it. They also emphasized the qualitative and quantitative escalation of the drug problem world wide and the related importance of the widest possible international participation in existing treaties.

US smokeless tobacco use up

By Harvey McConnell

WASHINGTON — Use of smokeless tobacco — snuff and chewing tobacco — is rising sharply among teenage boys in the United States, especially in the South and West, and poses serious risks of oral cancer.

A panel of experts from across the US at a consensus development conference sponsored by the US National Institutes of Health concluded in a final report that an estimated 10 million US people have used smokeless tobacco within the past year. Some three million of these users are under the age of 21 years.

Many of the experts think some smokers are switching to smokeless tobacco because they think it is a safe alternative for their nicotine dependence. Others suggest young people tire of smokeless tobacco and switch to cigarettes.

Smokeless tobacco releases nicotine into the bloodstream and produces blood levels of nicotine comparable to those produced by smoking tobacco. And, all the evidence is that smokeless tobacco is as addictive as smoking tobacco.

The consensus report points out that detailed national trends of smokeless tobacco use are not available, but it is known that sales which declined sharply from the 1930s to the 1960s have risen significantly since 1980. Annual sales now total $1 billion in the US.

A 1985 study by the US National Institute on Drug Abuse found 16% of males between 12 and 17 years of age had used some form of smokeless tobacco within the past year. Among this 16%, one-third used smokeless tobacco one or more times a week.

Local area studies have found that up to 40% of males in high school have been users. Use extended sometimes down to the third grade where 13% reported some sort of smokeless tobacco use. A study of college students found 20% of the males reported use.

Smokeless tobacco is used by only about 2% of females interviewed; its use among Hispanics and blacks is less than half that of whites.

Smokeless tobacco is most often used in the form of snuff: moist, which is packed leaves; and dry, which is powdered tobacco leaf.

The best case yet for assessing the risk of oral cancer from smokeless tobacco came from a 1981 study in North Carolina of snuff dipping by women. The study found that among the women who did not smoke, the risk of oral cancer was 4.2 times higher for those who dipped snuff than for those who did not.

In addition to cancer and gum and mouth disorders, smokeless tobacco is addictive: studies have found only a small percentage of teenagers were able to give up smokeless tobacco.

INSIDE

NEWS

Briefly ...

Sticker price

LANSING, Michigan — One cost is hidden when you buy a new car in the United States, say auto makers and union officials. About $175 of the sticker price on the average auto in new car showrooms across the US reflects the eost to industry of employees' alcohol and other drug abuse problems on the job. Furthermore, a US Senate subcommittee has been told by auto makers about 30% of those who want to work in the industry turn out to have substanee abuse problems, says *Monday Morning Report.*

Hitting home

LONDON — The British Medical Association has sent every Member of Parliament here statistics on how many of the MPs' constituents die each year from smoking-related diseases and how much their health care eosts, says *Medical World News.* "The Big Kill" campaign centres on 15 books of statistics on smoking's effects. "Though drug abuse and AIDS make headlines, smoking-indueed disease far outweighs their effects," Dr David Player, director-general of the Health Education Counеil here, said at a news conference launching the eampaign.

Dial S for Sober

PITTSBURGH — First, there was Dial-A-Prayer and Dial-A-Joke. Now, the Gateway Rehabilitation Center here has bcgun a national, toll-free telephone message service for people in the United States reeovering from alcoholism and other drug addiction. "Dial A Sober Thought" will be in operation 24 hours a day, and the message will be changed weekly, says a Gateway press release.

Where there's smoke

TORONTO — The proposed domed stadium here is already facing the wrath of the Non-Smokers' Rights Association because officials are considering cigarette advertising in the stadium, says *The Globe and Mail.* Imasco Ltd, owner of Imperial Tobacco Ltd, is one of 13 corporations slated to receive advertising privileges in exchange for a financial contribution to the project.

Goodbye to BYOB?

MONTREAL — Quebec diners who have enjoyed the privilege of bringing their own wine or beer to unlicensed restaurants may soon have to leave their supplies at home. *Canadian Press* reports that disgruntled owners of licensed restaurants are putting pressnre on the provincial government to stop the practice which has been booming since a loophole was discovered in a 1979 luw.

Learning how not to

ATLANTA — *Reader's Digest* magazine will nward $500,000 (Cdn $700,000) in scholarship funds to United States' stndents who devise the most sneeessful programs against ndolescent drunk driving. The magazine gave the challenge to stndents in its Jannary issue. In April, the teens will put their programs to work and provide documented results in May. Scholarships will be nwarded in June, the *PRIDE* newsletter here reports.

British Columbia surveys 'problem' motorists

Drunk drivers hazardous sober too

By Heather Walker

VANCOUVER — Motorists charged with driving while impaired (DWI) are also dangerous drivers in other respects, concludes a recent British Columbia survey.

"They have terrible driving records. They speed more, and get into more accidents than the average driver," Bill Mercer, PhD, and research director for BC's CounterAttack program, told **The Journal.** The program is directed at impaired drivers and is run by the Ministry of the Attorney-General.

The drinking driver problem, says Dr Mercer, is that of "the impaired problem driver as opposed to the impaired driver problem." His study shows those convicted of DWI usually have other traffic convictions and are unsafe drivers. Alcohol consumption is only part of their overall pattern.

Dr Mercer studied the driving records of a random sample of 9,273 BC residents between 1980 and 1984. The records were broken down into three groups: those who had not been convicted of DWI (8,992); those with one conviction (235); and, those with two or more convictions (46). (See related story, The Back Page.)

CounterAttack symbol

The groups were compared in terms of gender, age, conviction history, driver's licence suspension history, and recorded traffic accident history.

While acknowledging possible problems with the small sample size of those with more than one DWI conviction, Dr Mercer said his study found:

- the majority of those charged with DWI were male — 86.8% of those convicted once, and 93.5% of those convicted more than once;
- people between 21 and 30 years of age made up the largest segment (52.4%) of those convicted once and of those with more than one conviction (47.8%);
- while 40% of those with no impaired driving convictions had other driving offence convictions, the figure was 78.3% for those with one impaired driving conviction and 80.4% for those with more than one conviction;
- in a comparison of licence suspensions for offences other than DWI, only 1.4% of those with no DWI convictions had had their licences suspended; the rates for those with one DWI conviction and two or more DWI convictions were 19.6% and 32.6% respectively; and,
- DWI-convicted drivers had a higher rate of reported traffic accidents — 60.9% for those with two or more convictions, 50.6% for those with one conviction, and 20.9% for those with no convictions.

Dr Mercer said the study indicates the best way to combat drunk driving is to educate drivers on all aspects of traffic safety.

There is no requirement for any formal driver training in British Columbia, although drivers must pass both a written and a road test.

Industry accepts US elimination of smokeless ads

WASHINGTON — Tough health warnings on smokeless tobacco products and restrictions on advertising have been accepted by the smokeless tobacco industry in an unusual compromise with the United States Congress and medical organizations.

The industry has accepted rotating warnings, which will be highlighted by a well-defined "warning" headline, and which will read: "This product may cause oral cancer;" or, "This product may cause gum disease and tooth loss," or, "This product is not a safe alternative to cigarettes." Television and radio advertisements for smokeless tobacco are to be banned.

The decisions came out of a series of meetings with the industry, concerned legislators, and representatives of consumer and medical groups such as the American Heart Association, the American Lung Association, and the American Cancer Society. The laws have been working their way through Congress. (See US smokeless, page 1.)

It was pointed out that agreeing to the warnings on smokeless tobacco products would make it difficult for a user to blame future disease on a product which carried a health warning.

International cooperation on drugs objective of global health meeting

By Anne MacLennan

VIENNA — Health ministers from more than 20 countries meeting in London this month (March) are expected to call for new international commitment and cooperation to reduce the health and social problem caused by drugs.

The London meeting of ministers was called last year by the United Kingdom's health chief.

Representative health ministers from around the globe were invited to the meeting, organized in conjunction with the World Health Organization.

Observers here at the United Nations Commission on Narcotic Drugs say it's almost certain the ministers will call for increased government action on drug-related health and social ills.

The London meeting follows a special week-long session of the UN Commission on Narcotic Drugs devoted to developing an agenda for the 1987 world assembly of governments to discuss drug problems. That meeting, called for by the UN Secretary General Perez de Cuellar last year (**The Journal,** July, 1985), is now set for Vienna in June next year.

By the end of the first week of the two-week commission meeting here, health and social affairs delegates and observers were privately expressing concern about the increasingly heavy emphasis being put on law enforcement issues and powers in the global effort to reduce drug abuse. (See New drug treaty, page 1.)

DWI laws 'futile' without availability controls

(from page 1)

impact of severity is maintained depends on how certain arrest and punishment are."

The penalty in the new legislation considered most likely to have deterrent value is the mandatory one-year licence suspension. The deterrent value, however, again will be dependent on a driver's perception of the likelihood of being caught.

Mr Segal said in Ontario "enforcement interest is high," as evidenced by funding for equipment such as breath test machines and operation of RIDE (Reduce Impaired Driving Everywhere) programs to stop drinking drivers.

But, others believe that to be effective, drinking driving behavior must be changed long before it becomes a matter of police enforcement. And, they believe the provinces already hold the power to create major changes.

Dr Single: "It's futile to have a culture which is accepting of alcohol, governments which are constantly increasing availability, and then to expect to deal with the problem by increasing policing forces."

Controlling availability of alcohol, for example, through control of outlets and drinking age, is within provincial jurisdiction.

Dr Vingilis wants both drinking and driving ages raised: 40% of people involved in drinking driving accidents are between 16 and 24 years of age. Raising the drinking age would not eliminate drinking driving problems, but would reduce them. Raising the driving age might improve driving standards among young drivers.

A major benefit of raising the drinking age is to discourage drinking among younger people who find it that much more difficult to obtain alcohol. The drinking age has a "backward domino effect."

And, she added that "consistency of message" is essential between criminal law and social controls.

Mr Segal noted a gap in the new legislation. The amendments fail to increase the minimum penalty for leaving the scene of an accident. This gives the drinking driver the choice of "staying to face the music with an increased penalty," or running away knowing the penalty for doing so is not onerous and that even if caught, he or she may have sobered up sufficiently to escape the more severe penalties.

Urine testing should be routine

(from page 1)

contentious issue of testing teens: "I don't think parents should be able to take their kid's urine and go into a local lab to get a result. If parents are really concerned about possible drug use by teenage children, they should request that their pediatricians test for drugs as routinely as testing blood sugar levels for diabetes."

He and lawyer Robert Angarola have produced a monograph "which we hope clarifies both the policy and legal issues, and, we hope, answers everything you want to know about urine testing but didn't know enough to ask."

Correction

Two statistics in **The Journal**'s report on the *1984/85 National Drug Intelligence Estimate* were reported incorreetly in February. The cannabis seizures should have been 6,000 kilograms in 1984 and 46,000 kg in 1980.

— coming up in —

THE JOURNAL

- **The Street Is No Place for a Kid — a conference report**
- **The Senate Special Committee on Youth report**

NEWS

Police powers require government stand: Green

By Terri Etherington

TORONTO — The Canadian parliament has abdicated its responsibility to treat all citizens equally by allowing extraordinary powers of search and seizure in drug cases, says an attorney here.

And, while Canadian courts are beginning to recognize the inequities and deal with them under the Canadian Charter of Rights and Freedoms, the government continues to shift the burden of making changes onto the courts and of paying for those changes onto the citizen, says Mel Green.

Mr Green told a symposium here parliament has failed in its obligations to ensure police powers conform to constitutional standards.

"In my opinion, the search and seizure powers (**The Journal**, August, 1984) granted police across Canada in the enforcement of drug offences are simply extraordinary. They go well beyond the search and seizure powers granted police with respect to any other criminal offence — fraud, murder, break and enter, rape, anything.

"It is only with the advent of the Canadian Charter of Rights and Freedoms (**The Journal**, October, 1982) that police powers in these matters have come under strict judicial scrutiny," Mr Green said.

The courts are now recognizing that some of these powers, under the Narcotic Control Act (NCA) and the Food and Drugs Act (FDA), clearly breach a constitutional right.

Mr Green said they are asking "Why should drug offences be treated differently than any other offence? Why are the rights of the citizen any more tenuous or any more attenuated . . . because he happens to have a joint of marijuana in his pocket than if he has $500,000 from some advanced fraud scam?"

The courts, said Mr Green, "are doing the job, to some degree, of remedying the imbalance, of trying to ensure — to what degree they can — that all citizens are equally protected. But, in my view, that obligation rests initially, perhaps fundamentally, with parliament."

Parliament's failure to respond, Mr Green continued, leaves police not knowing exactly what the law is. "Even when they are acting in good faith, they no longer know whether they are acting constitutionally . . . unless it (the law) has already been validated by a higher court."

The accused — and ordinary citizens — are left in the same quandary.

"It leaves the citizen who is charged as a result of what may well be a constitutionally-invalid law having to bear the cost of invalidating the law — of proving in a court that, indeed, it does not meet the constitutional standard."

Under the NCA and the FDA, police are given sweeping powers of search and seizure, Mr Green told the symposium sponsored by Ontario's Addiction Research Foundation here.

The acts allow police to search places other than residences without a search warrant regardless of the drug sought or the amount of the drug involved. Thus, police have the same powers whether they are looking for one joint in an office desk drawer or for one ton of a drug in a warehouse.

In addition, once police have lawfully entered premises, they have the right to search any person found there, whether or not they even suspect that person is in possession of a narcotic.

Mr Green's arguments were countered by Michael Dambrot, a crown attorney and head of the prosecution group for the federal department of justice office here.

He said: "Most of the things Mr Green told you you should be fearful of, you no longer need to be fearful of, primarily as a result of the Charter of Rights and Freedoms."

In particular, section eight of the Charter says everyone has the right to be secure against unreasonable search and seizure. But, Mr Dambrot admitted: "Trying to understand what is an unreasonable search and seizure as opposed to a reasonable one is something that will occupy the time of our courts for many years."

While the NCA and the FDA do provide for search of places other than a dwelling house without a warrant, the Supreme Court of Canada has ruled that in order to prevent unjustified searches, where feasible, prior authorization in the form of a search warrant should be obtained.

And, the Ontario Court of Appeal, in a case concerning the search without a warrant of a man's office for a narcotic, ruled that the NCA violated the Charter in allowing such a search. Unless there was some special reason, such as the possibility that the drug would be destroyed or moved, a search warrant should be obtained before the search, the court said.

This decision is now binding in all courts in Ontario, although the NCA still provides for such searches without warrants, Mr Dambrot said.

Mr Dambrot believes the courts will take the same view of the power of police to search anyone found in a place being searched for narcotics. Courts, especially in British Columbia, which have dealt with that section of the NCA since the Charter, say the need to have reasonable suspicion that the person has a narcotic in his possession should be read into the section.

Research peers honor Canadian drug expert

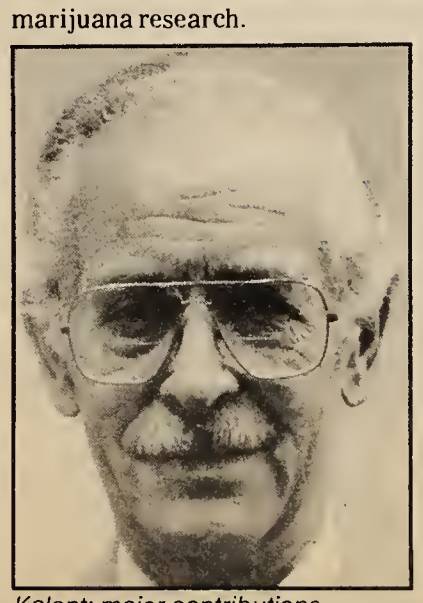
TORONTO — Harold Kalant, MD, PhD, has been awarded the 1986 Nathan B. Eddy award for outstanding research efforts in the field of drug dependence.

The award will be presented by the Committee on Problems of Drug Dependence at its annual meeting at Tahoe City, California in June.

Dr Kalant, director of biobehavioral research, Ontario's Addiction Research Foundation here, and professor, faculty of pharmacology, University of Toronto, was selected by a panel of international experts.

Louis S. Harris, department of pharmacology and toxicology, Medical College of Virginia, Richmond, said Dr Kalant's studies on the mechanism of action and dependence properties of ethanol "are internationally recognized as major contributions to our understanding of this most important drug of abuse."

Dr Kalant was also selected for his contributions in the field of marijuana research.



Kalant: major contributions

INSIDE OUT

Through the fire together

So, we stood on the street in the snow, under a light on a clear night, and we looked at each other.

It had all come down to this, a minute almost too precious, a minute to be lodged in the permanent memory bank, a minute to keep the heart quiet at all costs, act reserved, stay in control, and be cool — for just a few more moments.

Yes, I told myself, shivering in the cold, please, please don't let your poor heart go flying off now.

We kept on looking at each other, out of the corners of our eyes, we kept on saying goodbye, hesitantly, then really meaning it. We knew after a year together that the time was finally here. We joked a little and we told each other: "Next year, same time, same place."

And, we drifted away.

As I headed south looking for a cab, I dared not look back as they sauntered off into their own lives again. My eyes had filled with tears of thankfulness, pride, and an unadulterated love for them all, my small band, my brothers, my sisters.

We had been through the fire together. Somehow, for a blessed year, we had survived and now we had triumphed.

Nobody had ever told us before we met that bitterly cold morning at the rehabilitation clinic — without much hope at all, defeated, drowning in a depression beyond depression, surrounded by our shattered dreams, physically sick, sick in our souls too — just how great our non-achievement, going without a drink hour by hour, day by day, week by week, month by month, and now, blessedly, year by year, would suddenly loom later down the road for us.

What changes there had been, I thought, as I sat in the back of the taxi taking me away from them.

I remembered their faces that first morning, when we shambled in, looking like children who'd lost their mothers, and I wondered if I could possibly have seemed as forlorn to them as they were to me. But of course I had. We had come in stripped, we were open like raw wounds, we had had humility driven into us like spears.

But, now we were walking straight again, our eyes clear, our confidence returning.

The clinic had brought us together, from many parts, and although some of us had been more scared than we'd ever been before, there had been a heady anticipation in the air: we, who had avoided the truth about ourselves, were going to face it all, at last, and right there came our first gigantic liberation.

We knew the counsellors were genuine . . . that was the best part of the course

We became, in the next three weeks, pretty good students.

I was reminded then of what it must have been like for eager World War II veterans who'd lost five years overseas, the finest part of their young lives, when they had arrived back home, absolutely determined to absorb every nuance, every fact, idea, and notion, because they knew time was all any of us ever has — truly — it is our duty to use it well.

And, we had listened to the counsellors. Yes, we had listened, by which I mean, in this culture where listening has become an art as lost as blacksmithing, as if our lives depended on it. We had listened so hard, at each session throughout the day, that I felt drained when I left to go home at five o'clock. We had listened to the reasons why we had become as we were, to how we might escape the dead-ends of our lives. We had listened to Charlie, who'd been down and up and down and up and down again, and now was so up he was almost rarefied in his bravery and wisdom.

Mostly, though, we had listened to each other. Every time one of us spoke, everybody else nodded in affirmation: yes, that's how it really was, that's how it is, yes, yes, yes. Yes.

And we, who had each always had the supremely silly sensation we were special, learned the opposite: we were the same person.

Unspoken bonds formed, and we grew to laughing much of the time — never a killing laughter, not a hurtful one.

We went beyond that kind of laughter as the days passed. We entered the world of laughter that is freeing, because we weren't as defensive as we used to be, and we were finding that the best jokes of all are always on one's self.

We ate. That was the strangest thing for me. I'd become used to seeing food as an abstract notion in my drinking days. I used to observe food, much as one would a piece of sculpture. But, I had hardly ever consumed the stuff. Now, I was making up for it all with a proper vengeance — I was reading about food, paying attention to nutritionists, looking at vitamin bottles in drug stores, exploring every restaurant I could.

We played. We rediscovered a lost memory: we had bodies, and they were to be used, and so the air in the gymnasium became like a summer camp some days. We went for walks again, we strolled through the city, looking at it with brand new eyes.

We blurted out the truths about ourselves, some haltingly, some eloquently. We laid it on the table: we offered ourselves up. It was like speed-reading each other's soul. And, sometimes when I'd bump into people I knew and loved 'out there' in the world after a day inside the clinic, I didn't know how to tell them about it. "Going good," was about all I could get out. Going good? Going great, in that slow, steady, splendid way.

We watched films. Lord, did we watch films. Sometimes I thought I'd stumbled into a festival, let's say an Albanian film festival, and finally, by the end of the third week, there was a minor revolt, a healthy revolt. We were tired of seeing actors when we were living out the real thing.

We admired the counsellors who, we thought, were either the greatest actors of all or the best people we'd been lucky enough to have stumbled onto in years. How could they go on, we asked each other, listening to the same old dreary, predictable tales week after week, with each tale-teller convinced he had something new to offer.

We knew, of course, the counsellors were genuine: they weren't patronizing; they didn't scold. That was the best part of the course because if that trust hadn't been there then, not much would have been achieved no matter how sophisticated the therapy methods were.

When we learned that one of our counsellors had left to take a less-stressful job out in the world, we understood. It's hard to put it all on the line day after day. Hard as hell.

And we — who had deluded ourselves so successfully, had lied to ourselves so often — were touched with grace to be face-to-face with a sincerity that did not waver, does not waver now.

I wanted to tell them, so often, that when they wonder why they're doing what they do for a living, my small band, my brothers, my sisters, and I will gladly tell them. Thank you. You made all the difference to us.

Is there anything we can do for you?

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

DSM-III alcoholism criteria questioned

The DSM-III differentiation between alcohol abuse and alcohol dependence is of little prognostic value, says a one-year follow-up study of 403 male, primary alcoholics consecutively admitted to the alcohol treatment program of the San Diego Veterans Administration Medical Center between 1980 and 1983. Using DSM III criteria measured on admission, three San Diego physicians conducting the study found 186 men met the criteria for alcohol abuse and the remaining 217 met criteria for alcohol dependence. While DSM III states alcohol abuse involves at least one month of "pathological" alcohol use and signs of social impairment, a diagnosis of alcohol dependence additionally requires that the patient has either developed tolerance to alcohol or undergone withdrawal. Evaluation of the two groups found they were virtually identical except those classified as being alcohol dependent took more drinks per drinking day and had more alcohol-related medical problems. At one-year follow-up, the researchers found the data "revealed more similarities than differences between groups," with little difference in the death rate and number of alcohol-related social or medical problems between the two groups. The researchers speculated results might have been different with a sample of alcoholics from the general population because "it may be that once alcohol-related life problems are serious enough to result in hospitalization, the distinction between abuse and dependence diminishes." Still, they conclude, it makes little sense to subdivide a major disorder as is done in the DSM III unless the differences have far-reaching meaning.

American Journal of Psychiatry, December, 1985, v.142:1403-1408.

Smokers overload health services

Smokers are more likely to be sick than non-smokers. That is the conclusion of a study which evaluated the health of almost 24,000 British people older than 16 years. Two physicians and a medical statistician from the medical department, South West Thames Regional Health Authority, and the London School of Hygiene and Tropical Medicine, used the British 1980 general household survey to judge the general morbidity of smokers in the population. The survey included information on history of smoking and state of health. They found smokers suffered from chronic and acute illness more than non-smokers, and that this increased with the number of cigarettes smoked. Smokers also visited out-patient clinics significantly more often than non-smokers, and more ex-smokers tended to be sick than non-smokers no matter how long before the study they stopped smoking. The researchers say their findings emphasize the need to concentrate on primary prevention of ill health to reduce the load on the health services from use of tobacco.

British Medical Journal, December 14, 1985, v.291:1682.

Pat Rich

Sensory addiction within smoking should be studied too: researcher

By Lynn Payer

NEW YORK — Transdermal nicotine can help smokers resist the rise in cigarette craving that comes with deprivation and bears further investigation as a smoking-cessation technology.

Jed Rose, PhD, chief of the Nicotine Research Laboratory, Veterans Administration Medical Center, Brentwood, California, says sensory as well as pharmacologic components of smoking addiction ought to be studied.

He told the World Congress on the Pharmacologic Treatment of Tobacco Dependence here experiments showing that when the sensory components of smoking are separated from the pharmacologic ones, smokers prefer "the sensory components without nicotine, to nicotine without the sensory components."

Dr Rose found that in 10 cigarette smokers given eight milligrams of transdermal nicotine in a placebo-controlled, double-blind study, the transdermal nicotine prevented the rise in craving during a period of smoking cessation. The transdermal nicotine also reduced nicotine preference during periods when subjects were allowed to smoke various cigarettes.

"In principle, transdermal nicotine might have two significant advantages over nicotine gum: it might eliminate the problems of bad taste and gastrointestinal irritation because the skin is much tougher than the mucosa; and, it can minimize the effort needed by the patient, hopefully increasing compliance."

But, Dr Rose cited a problem with all nicotine-substitution approaches — they are not as satisfying as smoking. This may be because of the pharmacokinetics of administration or that such approaches lack the usual sensory reinforcing stimuli present in smoke — taste and the tracheal sensations accompanying each puff.

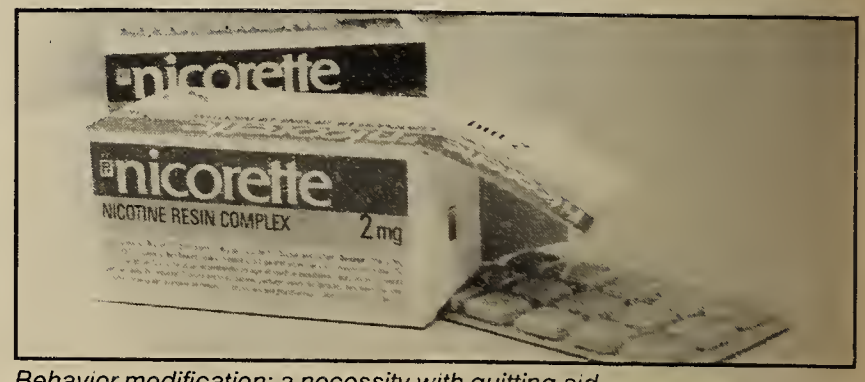
Nicotine gum failures blamed on MDs

NEW YORK — Doctors must take most of the responsibility for patient failures in using nicotine-laced chewing gum as an adjunct to smoking cessation.

The problems of nicotine chewing gum are not inherent in the product, but in the way it's used, adds John R. Hughes, MD, associate professor, department of psychiatry, University of Vermont College of Medicine, Burlington, Vermont.

While the United States Food and Drug Administration has approved the gum for use in conjunction with behavioral modification programs, "99.7% of people are not using the gum in this context," Dr Hughes told the World Congress on the Pharmacologic Treatment of Tobacco Dependence here.

Dr Hughes cited a survey which indicates only 32% of physicians spend more than 10 minutes with patients when prescribing the gum. Only 42% gave instructions on its use, 90% didn't tell patients to stop smoking completely, 90% didn't discuss side effects, and 88% didn't hand out a booklet provided with the gum. In addition, 84% of patients didn't have a one- or two-week follow-up.



Behavior modification: a necessity with quitting aid

"Physicians are clearly not using the recommended guidelines for giving out the gum," Dr Hughes said.

While there is some data suggesting nicotine gum is also useful in minimal-contact medical practice because of the specific effects of nicotine in the product, Dr Hughes maintains best results are obtained when behavioral modification training is combined with the prescription.

He adds that studies show the gum is effective only when people know it is laced with nicotine.

One of the major effects of the gum is that it may boost efforts by smokers to try to quit. The gum also promotes physician involvement in the anti-smoking effort, he says.

"If physicians have a prescription to give out, they're much more involved than if they don't."

HOWELL

And now, a time-limited offer

I receive a lot of junk mail. I throw most of it away unopened. There was a time when I used to open the magazine subscription letters (the ones that show a cheque WITH YOUR NAME ON IT through the little glassine window). But, I gave that up when my daughter grew too old to play with the colorful little magazine stamps enclosed. Now and then, I am still a sucker for the old DO YOU WANT TO BE A MILLIONAIRE? gambit. I should know better because it always turns out to be the same outfit flogging the same stock market books, the same real estate books, the same five (or is it 10?) easy steps to financial security.

I throw away a lot of junk mail addressed to Mr Howell and a lot of junk mail addressed to Dr Howell — the latter is often from pharmaceutical houses pushing junk drugs. But, how could I throw away a recent letter addressed to **Mr President and/or General W.A. Howell?** It is not every day that you are mistakenly assumed to be a leader of a Third World country.

The letter goes like this:

Dear **Mr President and/or General Howell** :
Are you sick and tired of the life you lead and the country you lead? Are you tired of being known as a "Third Worlder" at international conferences? Are you tired of being pushed around by bullies in the international commodities market? Don't you wish **you and Mrs Howawell** could get away for a week in Gstaad or Miami without having to worry about troublesome riots and coups back home? Wouldn't you like to move your country up THE LADDER OF SUCCESS into the Second World and the First?

If your answer to these questions is YES **Mr President and/or General Howell** , then do not hesitate. ENROLL TODAY in our GREAT NATIONS OF TOMORROW program. The GREAT NATIONS OF TOMORROW program will show you how to:

• THROW OFF THE LEGACY OF COLONIALISM — How many times have you asked yourself, how did we get into this mess anyway? Why don't we have enough food, why are we always behind in our balance of payments? The answer is YOU'VE BEEN SUCKERED

Remember how your nation was going to get rich by giving up subsistence farming and concentrating on one cash crop for the international market — on sugar, peanuts, cacao, or bananas? Remember how wonderful it all sounded? And, how wonderful it all seemed at first, when you were setting up the big estate farms and importing all that expensive harvesting machinery?

And, remember that awful sinking feeling you got on the day the GREAT NATIONS OF TODAY said, "Well sure, **Mr President and/or General Howell** that is a lovely crop you've got there but, well, there's a lot of that stuff around this year, and that's why we can only offer you pennies a pound for it?"

Remember that awful feeling you got when you realized that it wasn't the producing nation that set the market price IT WAS THE CONSUMING NATIONS? Remember the helpless feeling you got when you realized you owed those same nations a bundle for all the fancy machinery you bought; and, remember the riots in the streets when your people discovered that a diet of ONE THING ONLY — if you were lucky enough to have produced something that could be eaten — was not a proper diet at all?

If you are tired of BEING A SUCKER **Mr President and/or General Howell** then enroll today in the GREAT NATIONS OF TOMORROW program. It will not only show you how to Throw Off the Legacy of Colonialism, it will show you how to:

• BECOME YOUR OWN BOSS — Tired of cringing whenever your finance minister tells you the World Bank is on the phone? Tired of having to submit to all sorts of externally-imposed credit controls? Tired of having the GREAT NATIONS OF TODAY play with your economy like a cat plays with a mouse? Tired of having to justify that new 30 room wing on the palace you built for **you and Mrs Howell** to some New York or London banker?

Are you tired of all this **Mr President and/or General Howell** ?

Then, ENROLL TODAY in the GREAT NATIONS OF TOMORROW program and learn the secrets of success. STOP BEING A SUCKER START BEING A WINNER. Our program is based on MARKET-PROVEN STRATEGIES.

• There are certain cash crops that can only be effectively grown in countries with climates such as yours.

• These crops often flourish best on MARGINAL AGRICULTURAL LAND, leaving adequate areas for the growing of a variety of foodstuffs to nourish your people.

• These crops are in high demand. The GREAT NATIONS OF TODAY are incapable of controlling this demand and can do little or nothing to control international prices.

• Demand appears to be insatiable. Profits are incredible.

Using our MARKET-PROVEN STRATEGIES, you can BECOME YOUR OWN BOSS. Instead of having your post-colonial weakness exploited by the GREAT NATIONS OF TODAY, you can turn the tables and EXPLOIT THEIR WEAKNESSES.

All this sounds too good to be true, but believe me **Mr President and/or General How** , if you send away today for the GREAT NATIONS OF TOMORROW program (specify Beta or VHS for the audio-visual material), you will not be dissatisfied. We offer a THREE-YEAR, MONEY BACK GUARANTEE.

Think about it. And, if you have any doubts about embarking upon our program that will take your poor and struggling nation up THE LADDER OF SUCCESS, then consider this: do the people who control the prices of sugar, cacao, coffee, and bananas really leave you any choice?

By Wayne Howell

NEWS

Tobacco weakens health gains by poor: WHO

By Thomas Land

GENEVA — The executive board of the United Nations World Health Organization (WHO) has unanimously adopted a resolution that "tobacco smoking and the use of tobacco in all its forms is incompatible with the attainment of health for all by the year 2000."

The resolution demands legislative as well as administrative action in member countries to curb the global spread of the tobacco industry. This increases the pressure on governments to put public health before company profits and tax revenues.

The WHO, one of the most influential UN organizations, is committed to guide all countries in a coordinated effort to attain reasonable health standards everywhere by the turn of the century. But, its policy makers fear improvements in the poor countries — a result of decades of development efforts involving much of humanity — may well be destroyed by the "tobacco epidemic."

A special report before the 77th session of the WHO executive board here describes a global catastrophe caused by tobacco and resulting in a million deaths a year. It warns health authorities may be losing the fight against tobacco.

Tobacco is grown in about 120 countries, many of them in developing regions which have recently overtaken the rich world both in production and consumption of cigarettes. Many poor countries have entered the tobacco business in a big way during the past decade or two in the hope of raising foreign exchange income to finance economic development.

But, the bulk of the cigarettes produced in developing countries are also consumed there by a growing market. Because of the health hazards, the WHO has now told developing countries "tobacco production cannot be defended any more than production of other, even more lucrative crops — coca, opium poppy, or cannabis."

In most industrialized countries, smoking is on the decline. But, the report emphasizes, it's increasing in developing countries, "fueled mainly by intensive and ruthless promotional campaigns mounted by the multinational tobacco companies. In most developing countries, legislative controls and administrative measures — which in industrialized countries have already succeeded in limiting the use of tobacco — unfortunately do not exist or are at best inadequate."

The report predicts: "Smoking diseases will appear in the developing countries before communicable diseases and malnutrition have been controlled, and thus the gap between the rich and the poor regions will widen further."

The evidence of a causal relationship between tobacco use and ill health is overwhelming, the report says, and only the tobacco industry now denies the connection. The WHO executive board has thus called for government action to discourage smoking and to facilitate basic research on the effect of tobacco on public health.

The executive has also called on member states to implement strategies to ensure "that non-smokers receive effective protection, to which they are entitled, from involuntary exposure to tobacco smoke in closed public places, restaurants, transport, and places of work and entertainment."

Budget restrictions are the culprit

NIAAA chief's selection delayed

By Harvey McConnell

WASHINGTON — Forthcoming budget restrictions which helped precipitate Robert Niven's departure as director of the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA) will inevitably make his replacement a slow process.

It's expected to be several months before a replacement is found for Dr Niven, who resigned at the end of 1985 to take over as director of the alcoholism program at Wayne State University, Detroit, Michigan.

"Because the coming budget restrictions are about the worst we've seen since the Depression, I wouldn't be surprised if we finally get as NIAAA director a young fellow who is trying to build up his curriculum vitae and who would be willing to take over the institute for the last two years of the Reagan Administration whatever the budget costs are," a knowledgeable official said here.

Dr Niven's major aim when he took the NIAAA position more than two years ago was to upgrade the scientific aspects of the institute's mandate (**The Journal**, October, 1983). He was not expected then to make the position a career.

When budget restrictions coincided with an opportunity to resume academic activity, combined with research and clinical practice, he decided to leave Washington. Prior to joining NIAAA, Dr Niven, a psychiatrist, was director of the adolescent alcohol and drug abuse service at the Mayo Clinic in Rochester, Minnesota.

Loren Archer, often-time NIAAA acting director, will head the institute until Dr Niven is replaced.

Niven: returns to academia

GILBERT

Betel nuts, a psychotropic

In large parts of the Indian sub-continent and in much of the Southeast Asia, Malaysia, New Guinea, and Polynesia, the most popular form of psychotropic drug use is the chewing or eating of betel nuts. More than 200 million people practice the habit to experience the effects of arecoline, the main active ingredient of the nuts. Arecoline is thus the fourth most popular psychotropic drug in the world, after caffeine, alcohol, and nicotine, in that order. (In North America, the fourth most popular psychotropic drug is delta-nine-tetrahydrocannabinol, the principal active constituent of cannabis.)

This column will be a brief account of betel nuts, their use, and their effects. Next month, I'll report on my experience of betel-nut chewing in Toronto. Later this year, I will write about arecoline, a drug long relegated to the veterinarian's pharmacopeia as a vermifuge, but now being investigated as a memory stimulant in patients with Alzheimer's disease.

Common palm

Betel nuts are the fruit of the areca palm, also known as the betel palm, which is cultivated throughout the region for its yield. The botanical name is *Areca catechu*. Cultivation is taken most seriously in India, where agricultural researchers write articles for the journal *Indian Farming* with titles such as "Varietal improvement in areca nut," and "Areca nut research and development: a success story."

The areca palm is the most common and the characteristic palm of the region. It reaches 12 to 15 metres high with a slender, unbranched trunk topped by a crown of six to nine large fronds bearing up to 250 seeds or nuts a year, each the size of a nutmeg or small hen's egg. Most parts of the palm have commercial value, with uses from dyes to scaffolding and roofing material, but the nuts are much the most important product. Burton G. Burton-Bradley, a psychiatrist practising in Papua, New Guinea, has noted that "At times [the ingredients of a betel-nut chew] are the only merchandise on sale in the food markets of the coastal regions."

Areca nuts were misnamed betel nuts by 15th-century Portuguese explorers who confused the Malayalam words for the nut (*adekka*) and the leaf (*vettila*) that is one of the other two basic ingredients of the chew — the leaf of the betel pepper vine. The chew comprises a piece of nut wrapped in a betel leaf with a pinch of slaked lime, often prepared from burnt sea shells or coral. The combination is pressed against the inside of the cheek by the tongue and sucked.

The betel pepper vine (*Piper betle*), closely related to the vine that produces table pepper, is also cultivated extensively.

The hardened chewer would rather give up everything else in life than his betel chew

Its aromatic, breath-sweetening taste counters the hot, acrid astringency of the nut. Constituents of the leaf may also contribute to or modify the nut's pharmacological properties.

Slaked lime (calcium hydroxide) is added to make the mixture alkaline, because arecoline and the other alkaloids in the chew are better absorbed by the buccal membranes as oral pH rises. A study by Mathias Stricherz and Peter Pratt of the University of Guam, published in the journal *Pharmacology, Biochemistry & Behavior* in 1976, showed that omission of lime from the chew almost eliminated an effect of betel chewing on reaction time. With lime, chewing lengthened reaction time markedly and significantly, but only during the first five minutes of testing. Without lime, reaction time was hardly different from the no-chew condition. The authors attributed the effect on reaction time to the euphorogenic action of the chew.

According to Dr Burton-Bradley, in an article published in the *Canadian Journal of Psychiatry* in 1979. "The beginner experiences nausea, dizziness, vertigo, and cold perspiration. The taste is burning and acrid. He or she complains of a sore tongue. Habituation is soon established and these unpleasant symptoms tend to disappear. A feeling of well-being spreads throughout the body. A pleasant odor is imparted to the breath and is highly valued. There is little clouding of consciousness and an increased capacity for activity. I have known carpenters and stevedores who will not work without their chew. With mild forms of habituation, withdrawal symptoms are tolerated. In severe forms, a reversible psychosis may ensue, but this is rare. The hardened chewer would rather give up everything else in life than his betel chew."

A conspicuous effect of betel chewing is the production of copious amounts of bright red saliva and the frequent ejection of it by chewers. This aspect of the habit, wrote Dr Burton-Bradley, is the most offensive to non-chewers, particularly non-chewers from cultures of European origin. They complain that the saliva is unhygienic, stains public buildings, and is reminiscent of the blood-stained expectorate of tubercular victims.

Other reported effects of betel chewing include diminution of appetite, improved digestion, enhanced sexual performance, and sounder sleep. (None of these effects appears to have attracted experimental investigation.) Chronic use stains the teeth, but betel users confuse the effect by cosmetic blackening.

Oral cancer

The major risk associated with chronic use may be oral cancer. Epidemiological evidence suggests a higher incidence among betel chewers, but most of this occurs in chewers who add tobacco to the chew. Standard bacterial tests show arecoline to be mutagenic. Animal studies have shown the tumorigenicity of betel nut extract to be reduced when it is applied with extract of betel leaf.

In Thailand, young people in cities have ceased chewing betel nuts, with a consequent fall in the incidence of head and neck cancer. The main reason, apparently, is toothpaste advertising that promotes the attractiveness of white teeth, a virtue encouraged by the authorities. Young Thais have taken up smoking instead. Lung cancer is on the increase.

Betel-nut consumption practices vary considerably, particularly within India. In the northeastern hill regions, the nuts are eaten, together with betel leaves and lime. In other places, according to the location, tobacco or one or another of a range of spices, or both, are added to the chew. Ingredients include cloves, tamarind, cardamon, and resins.

Mental disease

Consumption by many chewers appears continuous, much as does smoking by heavy smokers. Nevertheless, betel chewing and its individual components have ritual functions in many cultures. Chews are offered and accepted to initiate and promote relationships, as cigarettes used to be offered and accepted in our culture. Nuts, leaves, and lime may be buried with the dead, to comfort the deceased in their journeys and to propitiate spirits. Betel chewing can be an important part of 'burying the hatchet,' sealing contracts and treaties, and above all, treating mental disorders.

Betel chewing can play one or both of two roles in the treatment of mental disease in Papua, New Guinea. It can aid the healer or therapist and it can aid the patient. "In the Koitabu area," wrote Dr Burton-Bradley, "mental disorder is treated by the *kava goto koitava* man who speaks magic words over the betel ingredients and gives them to the patient to chew. If he is not paid, the treatment is ineffective."

After 20 years of treating betel-chewing schizophrenic patients, Dr Burton-Bradley reported scepticism about the possibility of a relationship between the drug and the disease. Arecoline is nevertheless the subject of considerable research in North America as an enhancer of various kinds of behavior, some of which I shall describe in a later column. Next month, I shall report on the entirely legal sale and use of betel nuts, leaves, and lime in Canada's largest city.

By Richard Gilbert

EDITOR
Anne MacLennan

PRODUCTION EDITOR
Terri Etherington

CONTRIBUTING EDITORS
Karin Maltby (Toronto)
Harvey McConnell (Washington)

CONSULTANTS
Dr Oriana Josseau Kalant (Science)
Robert Solomon (Law)

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053 Advertising 595-6113 Subscriptions 595-6056

CORRESPONDENTS
John Carroll (New Brunswick)
Maureen Brosnahan (Winnipeg)
John Dornberg (Munich)
Manfred Jager (Winnipeg)
Tom Land (London)
Betty Lou Lee (Hamilton)
Alan Massam (London)
Lachlan MacQuarrie (Hong Kong)
Jean McCann (Cleveland)
Pat McCarthy (New Zealand)
David Milne (Toledo)
Lynn Payer (New York)

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Strong opposition from many quarters

Beer, wine in stores: an answer to Gilbert

In his November, 1985 column, Beer, wine, and groceries, Richard Gilbert provides a number of interesting interpretations and suggestions on an important issue.

He offers a critique of the Addiction Research Foundation's (ARF) Best Advice statement printed in the same issue, but concludes it is not a good idea to sell wine and beer in Ontario grocery stores. On this last point he is not alone. There is strong opposition to the proposal from many quarters. For some weeks, we've heard or seen very little on this issue in the media.

Last fall, it became evident the opposition included church and municipal leaders, police chiefs, liquor and beer distribution employees, public health agencies, citizens' groups against drunk driving, a large proportion of the general population, two opposition parties (representing the majority of Ontario legislators), and possibly some key members of the minority government. That's a fair showing.

There are many reasons for opposing the proposal: concern about jobs, quality of life, risks of increased public disorder and health problems, and long-term implications for our control and distribution systems in Ontario.

As is often the case, the media may be inclined to present those in opposition as puritanical, backward, unduly cautious, or naive. Since for some decades we have experienced, in haphazard dribs and drabs, increasing access to beverage alcohol, it is probably not surprising that the forecast of a downpour is expected to be met with boundless enthusiasm.

Proponents of increased access would have us believe we are living in a semi-drought; this runs counter to our experience, however. In the long run, doggedly following steps taken elsewhere, we may get greater access. But, do we need it? Dr Gilbert concludes we don't, and I concur.

But, I disagree with his interpretation of the possible dynamics following a move to place beer and wine into grocery stores and also his critique of the ARF statement.

There are three bases for the ARF statement: research studies on changes in access to alcohol, observations of patterns in Ontario, and extrapolations from estimates of increased sales realized from expansion of the retail network. This is tied together by the availability or control perspective.

Any one of these do not constitute research in the experimental sense, but it is research in that several lines of inquiry can be drawn together to develop a scenario of what might happen in Ontario.

The 1981 statement was based on several projections by the beverage industry of expected increases in domestic wine sales. The grocery store proposal adds beer, and one would not expect the 1981 projections to be in the wrong direction, as Dr Gilbert seems to think. Instead, they might be conservative.

True, the proportion increase might not be as great for a high-volume beverage category such as beer. But, I find no reasonable basis to conclude the two beverages would somehow change in the opposite direction and thus cancel each other out.

Proponents of increased access, the authors of two ARF statements, and, on balance, the research literature on the issue, would lead one to expect a net increase in the volume of sales, even allowing for some substitution at place of sale.

However, proponents of this move don't think it has any bearing on risk or problems, or don't really care. Many of those in opposition are concerned about various risks to health and social welfare. There are also serious implications for our control system. Among the advantages of a monopoly system, the ever-present potential for curtailing damage and death via judicious distribution and sale is a key one.

Dr Gilbert suggests increased access via geographic/spatial changes, when linked with higher prices, at least in a new network of private outlets, will drive overall sales down.

Giesbrecht: a fair showing

I'm puzzled. Even if the various factors lead to 100% substitution, this would still result in no change. He seems to be proposing 'super-substitution:' because something is more expensive at retail location G, the consumer will buy less of it in outlets, L, B, and W.

A major increase in access such as envisaged by the architects of the beer-wine proposal involves expansion of the off-premise network by many hundred percent. This move to facilitate sales is likely to overshadow whatever discouragement to buy follows from price increases.

Dr Gilbert knows price is a key in the relationship between access and sales. Social pressures, habits and fads, however, can deflate the power of economic variables. For example, during the International Nickel Company strike in Sudbury, Ontario, on premise — and expensive — beer sales held up better than off-premise sales.

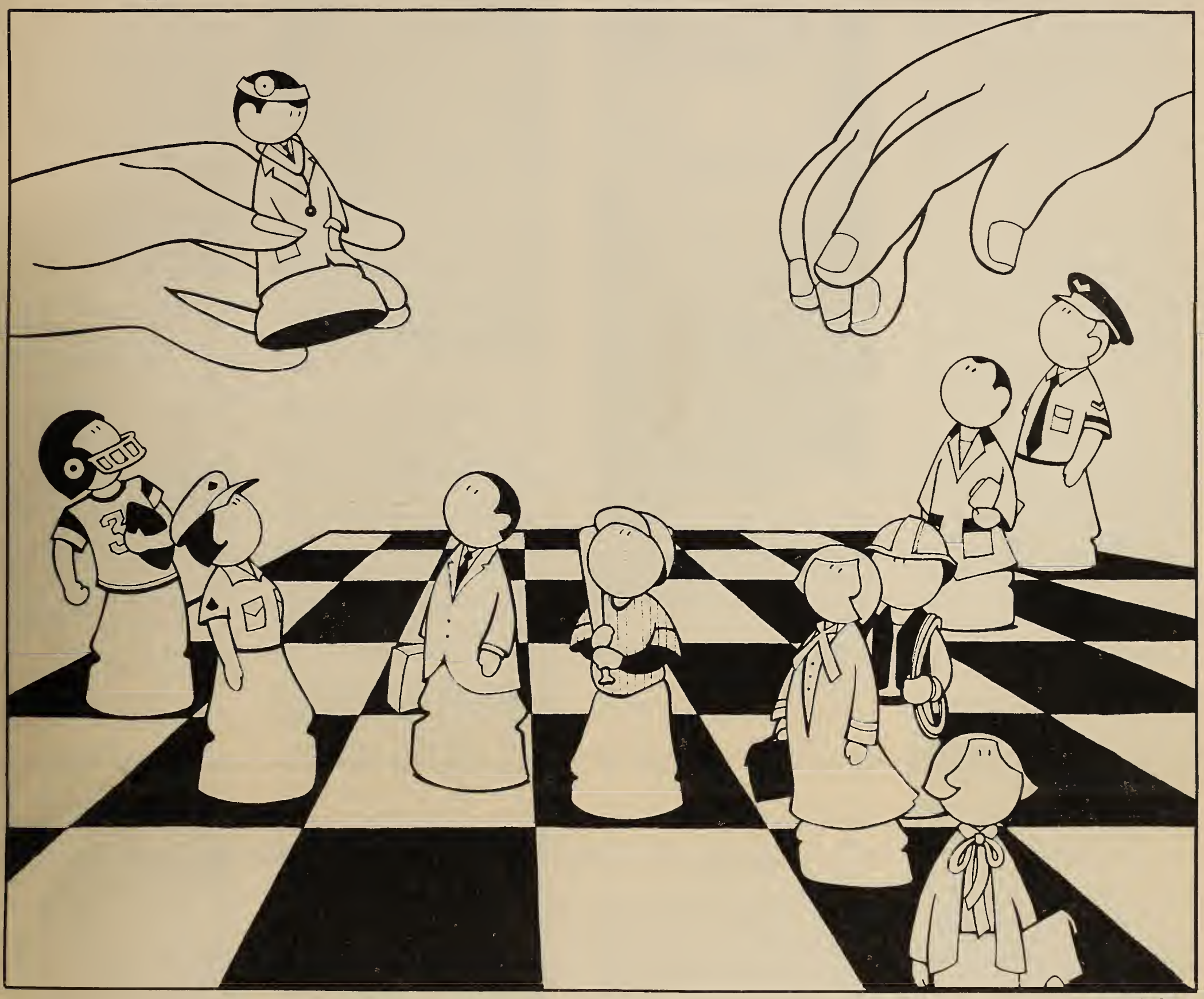
Will there be a consumption increase if beer and wine are sold via grocery stores? Very likely. There was with wine following the rapid expansion of Ontario winery outlets in the 1970s. And, that change involved a relatively-moderate increase in the absolute number of outlets, not a new, large network of outlets suggested by allowing beer and wine in grocery stores.

From time to time, Canadian or Ontario residents are presented with ideas from elsewhere. When it comes to alcohol accessibility, our response seems to be that if they're doing it in Abilene, Brighton, or Cannes, it's got to be right. In reality, the progressive, enlightened action would be to further promote effective prevention endeavors, rather than swallow these ideas hook, line, and sinker. Having our own soundly-reasoned views on key policy issues could be both innovative and appropriate.

Norman Giesbrecht, PhD
Prevention Studies Department
Addiction Research Foundation
Toronto, Ontario

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: **The Journal**, 33 Russell St, Toronto, Canada M5S 2S1.

Rights and responsibilities



Heather Graham

The ethics of urine screening

TORONTO — Urine testing for alcohol and other drug use is now a part of North American society, at work or at play, especially in sports activities.

As long as endemic drug use, licit or illicit, continues across the continent, the rationale for testing diverse groups of people — from those applying for both low- and high-paying jobs, to students seeking admission to schools (The Journal, November, 1985), to millionaire professional athletes — will grow.

There are major issues involved, and important questions are being asked: who should be tested?; when?; using what tests?; how good are the tests?; and, when do the rights of industry, sports, schools, public safety override those of the individuals involved?

No intellectually-dispassionate civil libertarian will contend that a bill of rights includes an individual's right to endanger fellow members of society through impairment from alcohol or other drugs, licit or illicit. But, who is to choose between the individual's rights and society's rights?

While urine testing in the workplace involves many more people, professional and college sport testing has taken many of the headlines in the popular press, from an agreement by some of the United States National Football League teams on voluntary screening, to mandatory testing approved by the US National Collegiate Athletic Association for championship basketball games and for all future football Bowl games.

Penalties will be harsh: any athlete with a positive test — with a second positive required for marijuana — will be ineligible for post-season competition; track and field athletes who test positive following an event will be stripped of any medals won.

The philosophical, legal, social, and practical aspects of the issues surrounding urine testing are being considered in a wide range of settings.

This special section of The Journal focuses on a discussion by professionals in the field during a meeting of The Journal's editorial advisory board and, as Contributing Editor Harvey McConnell reports, on a recent Washington conference on urine screening in the workplace, sponsored by the US Bureau of National Affairs. Mr McConnell also reports on the release of a monograph on the subject from the independent American Council on Drug Education in the US. (See page 1.)

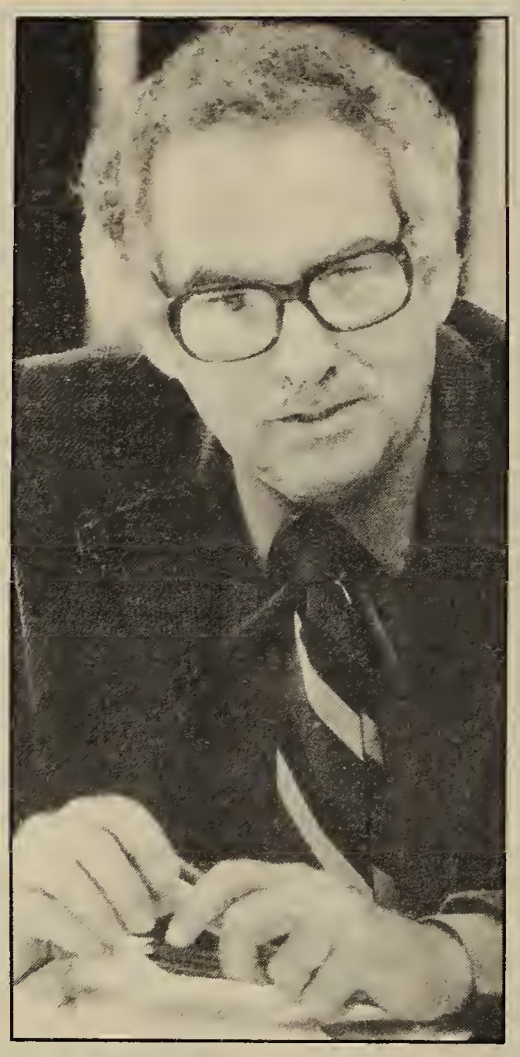
Rights and responsibilities

At the last meeting of **The Journal***'s Editorial Advisory Board, members, who are experts in their fields, discussed urine testing: the issues and implications.*

The discussion was led by Thomas Ungerleider, MD, professor of psychiatry, University of California Medical Center, Los Angeles. Dr Ungerleider sits on a committee to establish guidelines for urine screening of UCLA athletes and acts as a resource person for other college and professional athletic programs seeking guidance.

The Editorial Advisory Board members who participated include:

- ***H. David Archibald** — President, International Council on Alcohol and Addictions, and senior international adviser to* **The Journal.**
- **Senator Keith Davey** — *Canadian Senator and a former broadcaster, well-known as author of the Special Senate Committee on Mass Media report.*
- ***Joan Hollobon** — Contributing editor (Toronto),* **The Journal.**
- ***Harold Kalant**, MD, PhD — Director (biobehavioral research), Addiction Research Foundation (ARF), Toronto, and professor, faculty of pharmacology, University of Toronto.*
- ***Harvey McConnell** — Contributing editor (Washington),* **The Journal.**
- ***Albert Rose**, PhD — Professor Emeritus, faculty of social work, University of Toronto.*
- ***Wolfgang Schmidt**, PhD — Scientist, ARF, Toronto.*



Ungerleider: timely, controversial

Dr Ungerleider: In response to the chairman's request for a presentation of some of my current work, I'd like to talk about a timely topic which is controversial as well as chemical. The subject also has major social policy ramifications; these have been of special interest to me since the days when I served as a member of The United States National Commission on Marijuana and Drug Abuse (1971 to 1973).

The topic is urine testing in athletics, or: "Whose urine is it anyway?"

I come to this issue by accident. When the US hosted the Olympics at Los Angeles in 1984, many of the events were held at the University of California at Los Angeles (UCLA), which has a very sophisticated drug-testing laboratory and was the official Olympics' testing laboratory. So, when a variety of college athletic conferences, individual colleges, and even the National Collegiate Athletic Association (NCAA) became concerned about drug use among college athletes everywhere in the country, the input of those at UCLA, who had some experience, was sought.

I have been sitting on a university committee for more than a year now, considering a variety of issues about a urine-testing policy. The committee has not been able to come to consensus yet about the issues. The ramifications are very complicated.

I have also had numerous occasions to consult, informally, with the baseball commissioner's office, which is trying to implement urine testing in major league baseball.

The topic is timely and in the news every week. In fact, *Time* magazine (October 21, 1985) had a feature on urine testing because a school board in New Jersey voted to do mandatory urine testing of all the youngsters in a high school to search for drugs.

Peter Bensinger, formerly of the US Drug Enforcement Administration, says about a quarter of the *Fortune* 500 companies require job applicants to have urine tests when they apply for work.

Davoy: a real grip on kids

The Issues

In *Time*, these issues were raised:

- may an employer invade the privacy of workers even to the extent of inspecting their bodily fluids?; and,
- may employees be penalized for off-the-job indulgences which have no bearing on job performance?

The answers are unclear. Laws vary from jurisdiction to jurisdiction. The courts often try to distinguish between the examination of external evidence, like fingerprints or hair samples, and more "intrusive" tests like taking blood or urine.

The rationale that is being served is also relevant. For example, a test that would be reasonable for an airline pilot might be extreme for a ticket clerk.

As for the toxicological issues, there are some real complications. The drugs most likely to be abused by athletes are cocaine and alcohol, and neither of those drugs show up particularly long in the urine. Marijuana, on the other hand, which doesn't enhance performance, is a drug that can show up for weeks in the urine, depending on the amount taken. It is fat soluble and can be detected for a long time. So, the easiest drug to detect is not the drug that is going to be taken to cause a competitive advantage.

Drugs are excreted via the kidney (urine), gastrointestinal tract (stool), lung (expired air), skin (sweat), and mouth (saliva).

Some drugs (eg, cocaine, heroin) are changed to metabolites in the liver. Thus, a positive laboratory test depends on a number of factors including proper collection (eg, urinalysis), storage of the (correct individual's) urine, the concentration of the drug in the bodily fluids, and the sensitivity of the test (eg, chromatographic or immunoassay techniques). Some types of the former technique are subject to false positives and require further verification at significantly greater expense. One study by the (US) Centers for Disease Control monitored tests in a variety of labs and reported a 66% error rate.

Recent editions of **The Journal** have raised other issues:

- the real concerns and valid objections to urine screening as expressed by Carlton Turner (October, 1985); and,
- use of black market growth hormone, caffeine loading, and massive doses of bicarbonate tablets (September, 1985).

I'd like to raise some other issues, although I don't presume I can solve them.

Why test bodily fluids in athletes? The rationale has been to discourage the use of drugs — so, testing is presumably a deterrent. Precedence, of course, exists, not just in horse racing but in Olympic games testing.

Testing implies that drug education alone is ineffective. Just telling athletes drugs might be harmful doesn't seem to have much effect, and I think we would all agree it probably never could, considering the general milieu with the competitiveness, the premium on winning, the financial rewards in professional sports, and so forth.

We could test, some say, for the well-being of the athlete so that he (she) doesn't get involved in self-destructive behavior. But, that implies we will differentiate drug use (the kind the US National Commission described as experimental, recreational, or situational) from drug abuse — intensified, compulsive patterns which are destructive.

We may test for the "good of the game" — for example baseball, or for the good of a school, or a college.

People say athletes are identification models for youth, but, if that is true, what about the way we (US) permit the use of athletes to do alcohol commercials on television?

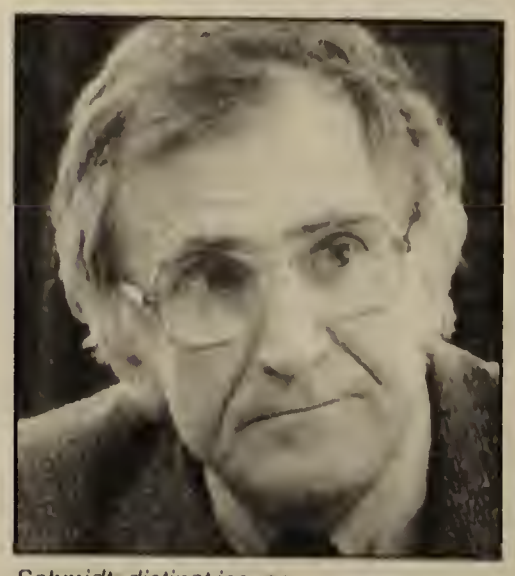
Another reason for testing, of course, is that the illegality of sale and use of many of these drugs requires involvement with so-called criminal types.

What drugs are being used by athletes? The drugs involved are both exogenous drugs foreign to the body and endogenous drugs, like growth hormone or testosterone-like steroids. I am not going to include the so-called blood doping or boosting in this discussion, but it refers to increasing the oxygen supply to the body by removing blood, storing it, and retransfusing it before an athletic event (**The Journal**, September, 1985).

Some of the drugs involved are legal drugs like alcohol, caffeine, bicarbonate, and steroids. Some may be legal or illegal depending on the circumstances, like amphetamines, or cocaine (which is rarely legal). Others are illegal drugs like heroin, marijuana, or Quaaludes (methaqualone).

Why are athletes using drugs? Some drugs are used by some athletes to attempt to enhance performance. But, there is some controversy about how much stimulants like cocaine and amphetamines actually do enhance performance.

The "Sunday syndrome," particularly among the defensive linemen in pro-football, has been well described. Stimulant drugs are used to induce a rage reaction, to enable them to "play hurt" (by potentiating with analgesics), and to increase their reaction time.



Schmidt: distinct issues

Some marksmen (rifleshooters) use alcohol before an event to relax themselves. Some also use drugs which will slow the heart rate — beta blockers — so they can squeeze off the shot between heartbeats.

Analgesics, of course, are widely used for pain; steroids are used to increase muscle mass — but not before a game — rather in the off season.

Some athletes use drugs to relax and for recreation — alcohol, marijuana, and cocaine — at other than practice, pre-game, or game times.

There is some self-medication by athletes. I'm thinking of those people who initially try stimulants, can't sleep at night, and then add an evening sedative. They get into the so-called "upper/downer" cycle of serious substance abuse.

Performance impairment may also be a result of drug use. Sometimes the risk of injury is increased by playing under the influence of a drug.

Some other major issues are germane to the question of why athletes use drugs:

- are there differences between *adults*, who are usually those playing professional sports, and *youth*, meaning the college athletes, most of whom are not yet 21 years old; and,
- what about the infringement on the freedom of so-called private behavior? (Whose bodily fluids are these anyway?)

Who is testing? Urinalyses are performed in industry to increase productivity and efficiency. These companies include IBM, the oil industry — Union Oil, Standard Oil, etc — and utilities like the Edison Company, railroads, etc.

There is also urine testing in the US military — army, navy, air force, and marines — including civilian employees. Here "sweeps" are made where, unannounced, everyone in a unit is tested. Pre-induction tests and subsequent testing "for cause" (if there is suspicion of use) are also employed.

There is also urine testing for those in what we call critical positions, like air-traffic controllers.

There is some form of urine testing in sport: teams from the National Football League (NFL), the National Basketball Association (NBA), and minor league baseball teams. In (US) college athletics, a partial list includes: the teams in the Big Eight Conference, Penn State, Colorado, Kansas State, Pitt, Georgia, Ohio State, Purdue, USC, Oregon, Arizona State, etc.

The NCAA is considering adopting a testing program. Reportedly, it is only going to cover performance-enhancing drugs, which are primarily the stimulants. One of their concerns was that testing for controlled substances *other* than performance-enhancing drugs would present major legal problems for a national athletics' governing body. Such legal restrictions are not necessarily applicable to individual institutions, however. Thus, there has been the development of locally-controlled and implemented testing programs. Some of the programs are with the agreement (of the athletes), some without. The agreements, theoretically, could be a college letter of intent, signed by an athlete when he or she agrees to attend a particular school.

What is the difference between athletes and other citizens? Are college athletes, for example, different from other college undergraduates, from intramural athletes, from dental students, medical students, fraternity students, etc? In one sense, they are. They are highly visible to the public via the media. Negative publicity conceivably could hurt the image of the school, and violations could result in suspensions of the team or the school by the conference or the NCAA.

Are professional ball players different from postal clerks, actors, attorneys, longshoremen, etc? Professional athletes are highly visible to the public by way of the media; they are highly paid, they represent a basic way of life in the United States. They are identification models for youth, their troubles — even the troubles of people they associate with — are well-publicized and reflect upon the sport.

If you are going to test, who are you going to test? At Purdue, they even test the cheerleaders. At Ohio State, the coaches, the trainers, and the managers are included. Some test intramural athletes as well as varsity. Some schools want

The ethics of urine screening

o test drug counsellors and lecturers, and ome plan to include team physicians.

Vhat drugs will you include? Just ille- al drugs? Those in the US Controlled Sub- tances Act? Or, illegal and legal sub- tances, including alcohol? The Olympics' ommittee drug list also includes caffeine. ome primarily test for marijuana; others or performance-enhancing drugs only.

Vill you test voluntarily, or involun- arily?

Iow do you test? This is more a techni- al question. Most colleges, the military, nd industry, test through urine. Some use reath samples. And, there is also a blood est that is possible but expensive and im- ractical.

Vhat type of test program will you mploy? These include periodic sweeps ke the military use, pre-employment, re-scholarship, pre-matriculation, test- ng with an annual pre-season or post-sea- on physical exam, or "for cause" — vhere suspicion exists.

Vhen do you test? During the season or ff-season; at spring practice; before, dur- ng, or after the daily practices; weekly, or nly once? During the playoffs or the regu- ar season? Before/after Bowl games, or ust during? Do you test at night, in the lorm, or just during the day?

Vhere do you test? Dormitories? Do you o into the privacy of the players' housing, n the field. in the training room, in the eam physician's office, or in the laborato- y?

And — the bottom line — what do you lo if both the screening test and the confirmatory test are positive? Do you ducate; do you warn; do you suspend or xpel; do you fine; or, do you send for ounselling?

Counselling is what many do, but that ails to look at the difference between drug se and abuse. All athletes with positive rug urine tests do not, necessarily, need reatment as drug abusers. Perhaps they eed education for being indiscreet enough o get caught, but not necessarily psycho- herapy or counselling for being a drug buser.

In summary — these are the issues. I on't have the definitive answers. I hope 've stimulated some thoughts. A number f schools have quickly begun testing pro- rams without much advance planning. Ve, at UCLA, are trying very hard to de- elop meaningful policy, but there are ery difficult issues here.

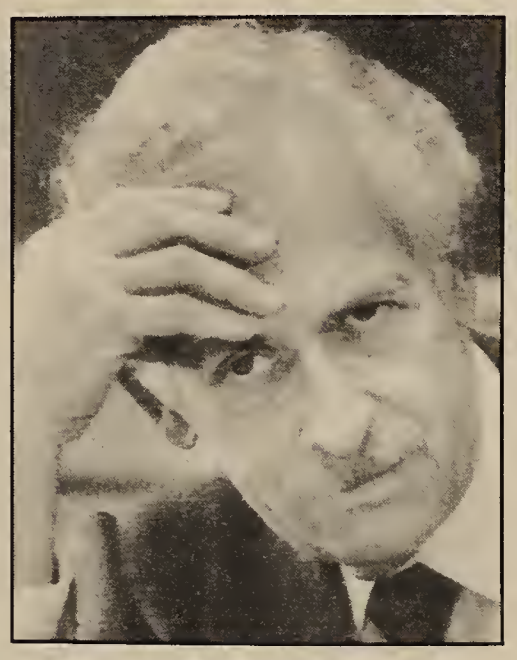
The Discussion

Harvey McConnell *(Contributing editor [Washington],* **The Journal***)*: What drugs would you, as a physician, think an athlete could use legitimately?

Dr Ungerleider: That is a philosophical is- ue. Are we talking about drugs that do not affect performance? Is the athlete, then, just like any other student? Am I talking as a university person or as a physician?

Dr Wolfgang Schmidt *(Scientist, ARF)*: I think you have essentially two issues. One, is the question of whether the substance af-

Archibald: setting a pattern



Kalant: role model function

fects the performance. In that respect, man and horse would be the same. What we do with horses, we would do with men.

But then, there is a second issue. We want the athlete to be an outstanding person with respect to his general life, and we want to make sure he doesn't use any of the substances which may reflect poorly on the university or his group. That is a very separate issue because it may be an athlete who uses drugs regularly but not in connection with his sport.

I think one should think of these two things as very distinct issues because if one doesn't, things become a bit confused.

Should the university say: "If you want to do sports at our university, we want you to be exemplary in every respect, including drug use? That means you voluntarily submit to that rule, and we are free to test as we see fit." That is one position.

Another position is to say: "If you want to create a fair, drug-free situation at the competition level of any sport, make sure that you enter this event free of drugs." You would then have a different set of rules for applications, testing to make sure that the person, once he enters that situation, is contaminant-free.

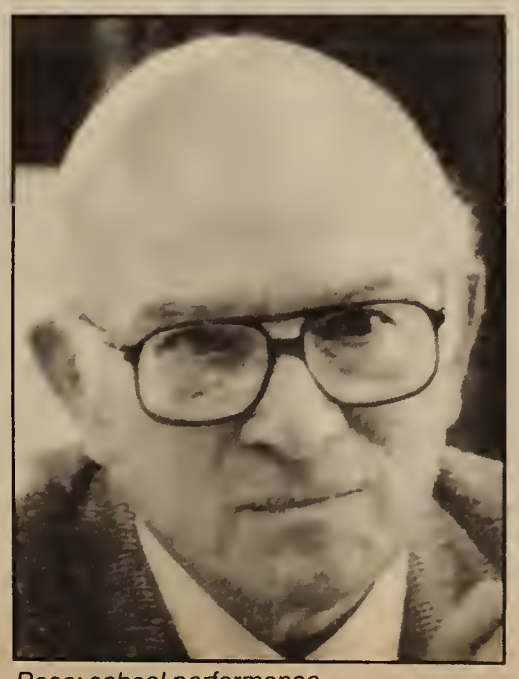
Dr Ungerleider: I think the US colleges would like the NCAA, the governing body, to make some kind of blanket rule because athletic competition is so fierce. Otherwise, a number of colleges will be hesitant to crack down if other schools in their conference do not. For winning means the coaches' jobs; it means championships; it means Bowl games which provide millions of dollars in extra revenue. We're talking big business.

Senator Keith Davey: Are there existing programs in the NFL and the NBA?

Dr Ungerleider: Yes, of sorts.

Senator Davey: And in baseball, the commissioner is in favor and the players' union is bucking it, presumably, or so they say, simply because of jurisdiction and approach — is that true?

Dr Ungerleider: I don't know exactly why they are against it. Some of the players who don't use drugs are requesting they be allowed to take the tests. I don't know all



Rose: school performance

the issues — of unions, collective bargaining, and the like.

Senator Davey: I find it terribly difficult to believe you don't have any answers. I wonder if you would favor us with, if not your answers, the direction that you are trying to go?

Dr Ungerleider: I certainly think that any kind of unfair advantage that one might get from competing under the influence of, say, a stimulant, should be prevented, even by urine testing.

It is much more difficult for me to know how you would, and if you should, create and enforce separate rules for athletes — even though they do reflect an image of a university — for something like marijuana. And, if you do test for marijuana, you've got to check for alcohol, because that is the primary drug that is abused on campus and everywhere in the US. There are a number of people who want to check for marijuana — because it is illegal — but not for alcohol.

The issue is complicated by the fact that, in most universities, a substantial amount of revenue comes in from beer companies. They sponsor athletic events, put full-page ads in the campus papers, etc. We've tried to point this out, but there have been some major problems — universities need revenue. The staff at our campus newspaper have said "who else can afford a full-page ad" (other than the beer companies)?

So, I would be more inclined to attempt to detect the drugs which enhance performance, like the stimulants. On the other hand, you can't test for (naturally occurring) growth hormone, and the cost of testing for steroids is extremely expensive.

Senator Davey: Do you differentiate between professional and amateur athletes? You make constant reference to universities, so let's talk about major league baseball for a moment. Would you not differentiate there?

Dr Ungerleider: I would not differentiate on performance-enhancing drugs.

Senator Davey: For performance-enhancing drugs, okay, the point is made. I'm relating for the moment with the role model aspect. It seems to me that baseball, in particular, has a real grip on kids. College football, on the other hand, has almost disappeared in Canada. I think a professional athlete has a special responsibility; certainly, I think baseball players do.

Dr Ungerleider: I think if you are talking role models, you must consider the ramifications. For example, among rock music and musicians, there is a tremendous amount of drug use. Now, certainly, the youth look up to these people, too — the kids fill the concert halls. The musicians certainly do have an influence on the kids. What about testing the musicians too?

Then, you must take it one step further — what about actors and actresses, people who are constantly before the public, are they role models? I don't have the answers to these things, but I think they are germane questions.

H. David Archibald *(President, International Council on Alcohol and Addictions)*: The overall trend is in the direction of testing, otherwise it would not be an issue.

Dr Ungerleider: But, the US military got into problems, as you know, with false positives — many have sued. They didn't handle mass testing well.

Mr Archibald: But, to some extent they are setting a pattern, are they not? And, I presume, it is a bit of a reflection not only of drug use but of a general movement toward conservatism. Where is the leadership going to come from? If you were omnipotent, what would you do? Would you move it in the direction of testing? You've already indicated you would in terms of performance-enhancing drugs.

You have also put your finger on an enormous number of issues, like testing in schools.

Dr Ungerleider: Unfortunately, without rules many shun their responsibilities. For example, I have been trying for about 15 years to get leaders of the recording industry to do something about the youth, the target audience who buy the records. To make these leaders aware, to fund teaching, treatment, alternates to drugs. And, they are totally disinterested, absolutely refusing to even consider such action because then people might think, if not badly, there was a connection between the music or the musicians and drugs. They'll put money into cancer and heart research and treatment but not into drug prevention or treatment.

Senator Davey: Rock music surely is pretty tough because there are thousands, I guess there are hundreds of thousands of groups, whereas a sport like professional baseball is pretty easy to deal with, surely.

Dr Albert Rose *(Professor, faculty of social work, University of Toronto)*: Have the programs gone far enough to be able to correlate the grades these people attain in college with any evidence of drug ingestion? To put it another way, does a performance-enhancing drug reduce the intellectual performance when it comes to the classroom?

In my day, football paid for every other sport; it probably still does.

My point is that the sequence goes all the way back to the high schools: these kids must get scholarships to college in order to follow the role models they have in mind to professional football, baseball, whatever. I wonder whether the old excluder — inadequate school performance — doesn't still work, and whether or not that is affected by drugs at either the upper high school level or even in college.

Dr Ungerleider: I don't know of any studies in which they've taken large numbers of people who use drugs vs non-users to look at effects on grades.

Dr Schmidt: It seems we talk about role models in sports and acting and music and they go hand-in-hand, to some extent, with the use of these drugs — at least from what I'm reading. Maybe these things are inseparable. To be a role model, you must use drugs — not as an individual, but as a group. And, if the group ceases to use drugs, it is no longer effective as a role model. It is conceivable.

Hollobon

McConnell

Dr Ungerleider: And, to keep the issue in perspective, there really is not that much of a drug problem at least at the college level, to my knowledge, except for alcohol — which is a major problem everywhere.

Another purpose that we have to be involved with is an educational one, and that is to prepare many of these athletes to adjust to the sudden riches which will come their way when they graduate from college and turn professional at 21 years of age. That is very young to get such a lot of money; they are not prepared for that at all. Their agents don't prepare them; nobody prepares them.

Dr Harold Kalant *(Director, biobehavioral research, ARF)*: Hearing all of the comments on role models, I can't help thinking that one is attributing a lot more importance to sports stars, actors, rock musicians, and so on, and not nearly enough importance to family, friends, classmates, and other everyday contacts. If you start tagging everybody who could function as a role model and say, "Well, they better have their urine tested too," we'll end up having obligatory tests for everybody in the whole society.

I wonder, do you know whether, in fact, there's any evidence based on actual studies of the role model function of public figures of this kind? To my knowledge, all of the literature indicates that role models are primarily people who come into contact with children at a very early stage.

(continued on page U4)

Rights and responsibilities

The ethics of urine screening

(continued from page U3)

They play the major role in shaping attitudes, expectations, and so on. Others may contribute later but, as far as I have understood it, the major role model function is served by family, close friends, classmates, teachers, and so on.

Dr Ungerleider: Staff of a local (California) newspaper went out on the street and to playgrounds recently to ask young baseball players what they thought about cocaine in professional baseball and how it affected them. Most of the kids were aware of it, but they said it didn't matter, they still liked baseball, and not drugs.

I believe people have turned to testing in a way because they have pretty much given up on changing the influence of the family or even peer pressure.

So, the question you've raised is a good one, where does it stop?

Dr Kalant: It really may be a matter of shifting responsibility to someone who is not in a position to reply. I can see a very practical reason for insisting on monitoring performance-enhancing drugs in athletes. That makes sense because, after all, professional sport is a big business, as you pointed out.

If you want to make sure that the betting is all fair and square and that there isn't fixing of games — that there isn't undue modification of performance by means that are not covered by the rules of the game — then you can make it an employment condition. "If you are going to be employed at this job, which is big sports, you have to do it fairly."

Anything beyond that I find hard to justify, given the fact that the whole society is not being tested.

Dr Ungerleider: But, some of our colleges take the position that we've got this wonderful Olympics' testing lab, and we could test for everything. It wouldn't cost any more — except for steroids — so they say, "Let's do it."

Dr Schmidt: The way we decide with horses may be the issue. What makes a horse run faster? What makes an athlete perform beyond his natural capacities? That is the question.

Joan Hollobon *(Contributing editor [Toronto],* **The Journal**): I'm just curious about the legal basis for this. I could see why a professional club would say: "All right, you've joined the club, and this is a condition of employment." Even to an amateur college team, possibly this could be done.

On any wider basis, it would seem to me you would have to have new legislation or something — which sounds highly dangerous.

Dr Rose: Isn't there a difference, too, between employees and private entrepreneurs? The rock group is a business. It's their own business; they agree to perform. You have no right to invade their bodies because you think that these kids sitting there on the grass are going to be affected in some fashion — are going to be affected in their view of a role model.

But, other people are employees. Somebody said college football people are employees; they are. They get money, there is no question about it — they get scholarships, free tuition, all sorts of benefits. And, they get a chance to be millionaires.

Mr Archibald: Most of the discussion has centred around university athletes and so on. But, you have also raised the issue of the number of industries that, in fact, are starting to either think of, or already impose, testing procedures as a condition of employment. This raises again some equally fundamental questions.

For instance, for such occupational groups as air-traffic controllers or pilots, etc, one can run into the danger of getting into specifying certain categories of people who: "For my own sake, are going to take the test."

I guess the state of the field is really trying to put the finger on very specific issues that are important for the community-at-large to begin to address and attempting to get some insight on the direction that things should go. We are really just raising the issues; obviously there are no clear answers to this.

Dr Schmidt: I think the way you propose it is the way to go. You identify the highest risk with respect to society as a whole and you begin introducing testing for such high-risk groups with respect to the harm they can cause. And then, you work your way down.

WASHINGTON — The line in urine screening between the rights of the individual in given situations compared with those of employers, plus the issue of public safety have still to have definitive rulings made by the courts. Contributing Editor Harvey McConnell reports on a recent conference here on urine screening in the workplace, sponsored by the private Bureau of National Affairs.

Legal issues

United States' courts and state legislatures will ultimately decide whether drug testing is fair and reasonable and under what circumstances it can be carried out, predicts Alfred Klein, former senior attorney for the Atlantic Richfield Company and now a consultant in Los Angeles.

At present, the legal issues regarding alcohol and other drug use in the workplace are, for the most part, subject to speculation rather than application of clearly-defined legal precedent.

Mr Klein said arbitration doctrines often find their way into judicial precedents, and decisions on alcohol and other drug use in the workplace should be studied for trends and consensus: they may form the basis for similar argument in court cases now pending or which may evolve in the future.

Conjecture and argument rather than binding precedent decide, at the moment, the extent to which the right to be free from unreasonable intrusions counterbalances an employer's right to maintain safety and efficiency.

Arbitrators, in the main, seem to accept drug screens as a legitimate exercise of management's responsibility to maintain safety, efficiency, and discipline. The right to ask for a drug screen is accepted, but close scrutiny is being given to how the results are used.

Applicants with positive results are invited to provide an explanation before a final decision on hiring them is reached.

At present, pre-employment drug screens do not violate any existing state or federal statute or any common law doctrine if they are performed in a reasonable manner. However, it seems certain that the issue will be raised eventually in the courts.

For example, Mr Klein explained, a company would be happy with a 99% accurate screen; a less than 1% false-positive reading would be considered an acceptable margin of error. But, if one applied the same rate to one million screens, it would mean that about 10,000 people could be adversely affected.

Thus, the prospect of thousands of potential employees wrongly excluded from employment means "the low degree of error pales in significance to the stigma of erroneous rejection as an abuser of drugs or alcohol.

"Employer's are certainly not required to solve all of society's drug and alcohol problems through their EAPs (employee assistance programs)," Mr Klein continued. "If individuals have a second chance to pass, it could be argued they could refrain from drug abuse only long enough to pass the test and then resume previous habits."

While courts and legislatures will eventually decide what is fair and reasonable, he concluded: "If employers exercise responsibility and fairness in performing drug screens and in analyzing and responding to their results, they will reduce the possibilities of onerous or widespread restrictions."

Test reliability

The time to consider the reliability of drug tests and the significance of drug use in the workplace is before a company starts a testing program, not later.

D. Joe Boone, PhD, division of technology evaluation and assistance of the Centers for Disease Control, Atlanta, has evaluated with colleagues a number of drug test techniques and laboratories and reported in the medical literature.

He told the conference while it is now common to include concern about security, job-related accidents and injuries, and job performance as reasons for conducting drug tests, testing remains a controversial issue. This is partly attributable "to employees and management not understanding the tests themselves, nor the meaning of test results."

While a urine sample can show that a specific metabolite was present in detectable amounts at the time the specimen was taken, "it is not possible to infer from test results of a single, randomly-collected urine specimen the time the drug was used, or the time when a person's functions were impaired," Dr Boone added.

It is vital to determine at the start where the laboratory decides a cut-off point is for a positive sample. The company should review the cut-off points because if they are set inappropriately high, drug abuse will be missed, and if they are set inappropriately low, drug use may be detected for days or weeks later and will need confirmatory testing.

Dr Boone said each specimen, as a rule, should be collected and handled as if the results were going to be used in a court proceeding.

Experts may be needed to find a reasonably-priced, reliable laboratory. Many laboratories will provide a limited number of free analyses.

Price should be the last consideration. "In this field, as in most others, you usually get what you pay for," Dr Boone observed.

"The cost to the company of one badly botched laboratory test could be far greater than any savings in testing fees. A suit that is won on charges of false accusation of drug use, or an accident that occurs involving an employee whose drug use was missed, may destroy the entire drug-testing program."

Because serious consequences can result from a false-positive report, laboratories have adjusted their day-to-day operation to use a higher concentration as their cut-off point when, in fact, their methodology is quite capable of detecting positive results at a lower level. Dr Boone pointed out this can lead to under-reporting of drug use.

Dr Boone: "If a company wants a realistic picture of the drug use among its employees, it must encourage the laboratory to report what the science of drug testing will permit. If a company is not willing to take this step, it should monitor the laboratory constantly to determine the 'true' error rate for its testing program."

Individual dignity

The challenge in pre-employment and post-employment drug testing is to develop a system which is impartial, objective, and accurate while continuing to respect the dignity of the individual.

This is the opinion of John Williamson, manager of industrial relations with Carpenter Technology Corporation, Bridgeport, Connecticut, a specialist steelmaker. He works closely with the company's employee assistance program, which was put into effect in 1973.

Mr Williamson pointed out his company has pre-employment screens and is currently considering post-employment screening.

The difference in cost between a limited and full scope analysis is not that great. The company chose an independent laboratory to do the testing. Applicants for jobs are told they will be tested for alcohol and other drugs and sign a release. They are given several chances to declare drugs they are taking which may appear in the results.

Applicants who declare they are using medication can indicate what drugs they have been prescribed. If necessary, the company's medical director can consult with applicants' doctors.

Mr Williamson said if a test is positive, the laboratory does a second test, using different methodology on a retained portion of the urine sample, for verification.

More difficult by far is consideration of a testing program for all current employees.

"It is one thing to be supportive of testing the applicants out there. It is something else to realize that you, your buddy, your best operator or engineer may be tested."

Many applicants, when informed of a positive test result, do not appear to consider having alcohol or other drugs in their systems as significant, especially when marijuana is involved.

Mr Williamson said the union at the plant — United Steelworkers of America — favors the test because it does not want to be saddled with defending problem employees.

Defence force problem: 1973 Yom Kippur war meant drafting "problematic" youngsters for service

Court says Israel can jail soldiers refusing drug tests

By Michael Kesse

TEL AVIV — The Israel Defence Force's (IDF) Court of Appeals has ruled that any soldier suspected of taking drugs must undergo a urine test or face imprisonment.

The outcome of this urine test would be considered as "sole evidence" of drug taking.

A decision to the same effect by a lower court was appealed on the grounds that such a urine test was an invasion of privacy and violated a soldier's "basic rights."

The use of soft drugs became a problem in the IDF immediately after the 1973 Yom Kippur war when it was decided to draft many so-called "problematic" youngsters. However, those on hard drugs were not drafted. Later, many soldiers who served in Lebanon, which is famous for its hashish, picked up the habit there.

Recently, the IDF reported to the Knesset (Israel parliament) that 400 soldiers were charged and found guilty of using hashish in the 1984/85 fiscal year. These 400 soldiers included only a few officers.

During the same fiscal year, 9,569 soldiers suspected of smoking hashish were forced to provide a urine sample. Results indicated that 778 had used cannabis, and files were opened against 619 of them.

Light beer wins place in NZ grocery stores

By Pat McCarthy

AUCKLAND, NZ — Low-alcohol beer has won a place on the shelves of supermarkets here, following a Court of Appeal ruling that it is not legally beer because "it is not intoxicating."

And, the low-alcohol product has coincidentally been made cheaper by government legislation declaring it *is* beer and not "soft drink" — therefore attracting beer duty rather than sales tax, which is higher.

The court's decision applies to beer containing more than 1.14% alcohol by volume, the level for defining "liquor" in the Sale of Liquor Act.

The legislation, reclassifying soft drinks in terms of the Customs and Beer Duty Acts, applies to beer of 0.5% to 1.7% strength. It has cut the price of an imported can from approximately one dollar to 90 cents (Cdn 67 cents).

The test case to the appeal court came after a supermarket chain started stocking two imported beers — Isenbeck from Germany (1.45%) and Northern Light from Australia (0.98%).

Police considered the supermarket sales legal, but the hotel association, anxious to restrict the sale of alcoholic beverages to licensed premises, launched court action. The hotel keepers won in High Court, but the supermarket group appealed.

In the latest decision, appeal court President Sir Owen Woodhouse said the court was unanimously satisfied that the definition of "beer" in the Sale of Liquor Act was not intended to include low-strength brews.

Another judge said: "The essential attribute of beer is that it is intoxicating. That is its ordinary popular meaning. There would be no point in making the Sale of Liquor Act applicable to a liquid unless it had that intoxicating property."

The court accepted evidence by Richard Batt, professor of biochemistry at Massey University, Palmerston North, and director of the university's alcohol research unit.

He told the High Court the average person could not take in enough liquid containing less than 1% alcohol to become intoxicated.

As low-strength beers returned to supermarket shelves, they also began appearing in service stations, video game parlors, and unlicensed restaurants.

The Alcoholic Liquor Advisory Council, which advises the government on liquor matters, was disappointed by the ruling. Its director, Keith Evans, said anything containing alcohol that was packaged and marketed as an alcoholic beverage should not be sold in supermarkets.

Nicotine nose drops could help smokers quit

By Alan Massam

LONDON — Health education urging smokers to give up the weed is having some success, but there is little doubt some smokers are unable to quit because they are addicted to nicotine.

This was a factor considered by delegates to the recent First World Congress on the Pharmacologic Treatment of Tobacco Dependence held in New York, NY.

British delegates were led by Michael Russell, MD, reader in addiction at the Maudsley Hospital. Dr Russell has urged more sympathy for addicted smokers and searched for pharmacological alternatives to deal with the craving for nicotine.

One of Dr Russell's colleagues, Martin Jarvis, MD, told the New York conference research at the Institute of Psychiatry's Addiction Research Unit in London led to the development of nasal nicotine solution (NNS). NNS can be administered in droplet form into the nose. He said preliminary clinical trials are evaluating the solution as a temporary source of nicotine replacement after smoking cessation (**The Journa**l, April, 1983).

A two-milligram dose of NNS gives a blood-nicotine concentration about halfway between nicotine chewing gum and smoking. But, the peak nicotine concentration occurs after about seven to 10 minutes after administration — which was similar to smoking and considerably shorter than the 30 minutes needed to achieve peak nicotine concentration from nicotine chewing gum.

Clinical evaluation suggests NNS is well accepted, with rapid adaptation to local irritation caused by the NNS droplet.

Dr Jarvis said the solution might be particularly useful for very heavy smokers and useful for investigating the effects of nicotine.

Jack Henningfield, PhD, department of psychiatry and behavioral science, Johns Hopkins University, Baltimore, told the conference there is a three-fold scientific basis for regarding compulsive tobacco use as a form of drug dependence. These are:

- tobacco use shares many factors with previously studied forms of drug dependence, notably opioid dependence;
- the rate and pattern of cigarette smoking are partially determined by nicotine dose levels; and,
- nicotine meets established criteria as a prototypic drug of abuse.

Younger kibbutzim settlers more accepting of alcohol

TEL AVIV — Attitudes in *kibbutzim* (communal settlements) to drinking alcohol is changing from generation to generation. Moreover, within the same family, the last born is more likely to drink and use other drugs than the first born.

These findings emerged from two surveys presented at the 1st World Congress on Drugs and Alcohol here.

Yaacov Naisberg, MD, director of Community Mental Health Services, Rambam Medical Center, Haifa, said a five-year survey of six kibbutzim in the Haifa area shows "there is a distinct change in attitudes on drinking from generation to generation."

The first generation — generally the kibbutz founders — lean toward sobriety. But, the next generation — those born within the kibbutzim — try to avoid personal contact with those who drink. The third generation holds a liberal attitude and approach, often creating a minor social crisis with parents and grandparents, Dr Naisberg explained.

Michael Nathan, Institute of Research on Kibbutz Education, School of Education of the Kibbutz Movement, Oranim, Kiryat Tivon, said a survey of 981 kibbutz-born adolescents who were in the last three years of high school showed the use of alcohol and other drugs was more prevalent among the youngsters born latest and least prevalent among the first born.

Mr Nathan: "The youngest born were more prone to share their problems with their peer group than older children; but, the first and middle born tended to approach parents or other adults more than their youngest siblings."

NEWS

Tobacco ads useful in fighting smoking?

By Terri Etherington

WASHINGTON — The timing is right for a public health counter-attack on cigarettes and cigarette advertising, says a Western Kentucky University researcher.

Paul Tanner, PhD, told delegates to the annual meeting here of the American Public Health Association to fight back by pointing out the inconsistencies, the covert messages, and the sophistries used by tobacco advertisers.

Credibility of the ads, says Dr Tanner, is cigarette manufacturers' Achilles heel.

"I think they have done a lot to hurt their credibility, but we can do more to help them down the road."

Dr Tanner: "Cigarette manufacturers are able to allow themselves to become loose with the truth — which those of us with a more scientific background have a little problem with. And, I think they use that against us."

It is time, he said, for health educators to use those advertising "mistruths" against the manufacturers.

Referring to ads, Dr Tanner said: "Kids have drummed into them all kinds of subtle messages.

"I think they (the manufacturers) really don't want kids to smoke. They just know that if they don't get them to smoke when they are kids, they won't get them to smoke."

Studies show that after age 25 years only a small percentage of people will start smoking: a Texas study on chewing tobacco revealed 88% had started by age 14 years and 24% by age eight or nine years.

Of ads aimed at women, Dr Tanner said educators could use the slogan of the Virginia Slims brand of cigarettes — "You've come a long way baby" — against the company itself. Philip Morris, makers of Virginia Slims, has only one woman among its top 50 executives.

"I think we can use that kind of thing against them. They have been using the feminist movement, equality, and so on, and we see that they are very hypocritical — that they have simply used it for their own means."

Smoking is becoming "increasingly uncool," and there are indications of infighting among the manufacturers, he said. "Now is the time to push this while we've really got them down."

Smokers also bothered by passive smoke: study

WASHINGTON — Even smokers — up to one-third of them — are bothered by other people's cigarettes.

And, respondents to an Ontario study of knowledge of and attitudes toward tobacco health risks and smoking regulations said they would be more likely to ask smokers to butt out if there were non-smoking regulations to back their requests.

The study was reported here at the American Public Health Association's annual meeting.

Linda Pederson, PhD, associate professor of epidemiology and biostatistics, University of Western Ontario, London, told the conference smokers as well non-smokers (both never-smokers and ex-smokers) favor increased regulation.

Previous surveys have studied attitudes on active smoking, but Dr Pederson said this is the first study to assess both knowledge of and attitudes to passive smoking.

Dr Pederson: "When governments are considering the kind or extent of regulations . . . the acceptability of such controls should be a major factor."

For instance, smokers and non-smokers agree on prohibition of smoking in stores, and the majority in both groups also favor prohibition in schools, hospitals, and doctors' offices. But, in places of entertainment, such as restaurants and theatres, at public gatherings, and in workplaces, non-smokers are much more in favor of restrictions than smokers.

Implementing controls may not be enough, Dr Pederson said.

"Although there are few areas in Ontario that do not have at least some restrictions on smoking, only about half of the two non-smoking groups are aware of this."

Although the non-smokers said they were bothered by cigarettes, "they weren't keen on being aggressive." If regulations were in place, or if people were aware of current restrictions, they would be more likely to ask smokers to stop," she told **The Journal**.

RCMP honored for publications

OTTAWA — For the second consecutive year, the Drug Enforcement Directorate of the Royal Canadian Mounted Police (RCMP) has been honored for excellence in law enforcement publications.

The 1985 professional service award was presented at the annual conference in Houston, Texas of the International Association of Law Enforcement Intelligence Analysts.

Accepting the plaque were Robert C. Fahlman, chief, Shelley A. Keele, senior intelligence analyst, and Hélène Vigeant, intelligence analyst, all of the RCMP strategic analysis and publications section here.

New Books

by MARGY CHAN

Maintaining and Enriching Your EAP: The Role of the Joint Committee

. . . by Wayne Weagle and Gordon Skead

Adopting a formal employee assistance program (EAP) policy is only the first step toward a successful EAP program. An active, joint labor/management committee can help to maintain and enhance such a program. This book is intended as a resource guide for a joint committee. It identifies critical problem areas, provides realistic approaches, and offers alternative solutions. It is well laid out, clearly illustrated, and very readable.

Performance Resource Press Inc, 2145 Crooks Rd, Ste 103, Troy, Michigan 48084. 1984. 50p. $5.95. ISBN 0-9610026-3-8. Canadian orders: Alcoholism and Drug Dependency Commission of New Brunswick, PO Box 6000, Fredericton, New Brunswick E3B 5H1.

Alcohol and Aggression

. . . edited by Paul F. Brain

The relationship between drinking and violence is a recurrent media topic. This book is intended to provide readers with an honest evaluation of the problems inherent in attempts to relate alcohol to aggressive behavior.

Based on recent scientific studies — animal experiments, clinical and social research — the book examines the nature of aggression; the biochemical, hormonal, and neurophysiological effects of alcohol, and the experience of such changes in behavior terms; the problems related to the nature and treatment of data collection; and, the socio-cultural factors in alcohol-related aggression.

This book will interest workers in animal behavior, alcohol studies, psychopharmacology, and social psychology as well as laymen who want to be well informed on such a controversial issue.

Croom Helm Ltd, 51 Washington St, Dover, New Hampshire 03820. 1985. 228p. $37.75. ISBN 0-7099-0691-9.

Alcoholism: An Inherited Disease

. . . from the US National Institute on Alcohol Abuse and Alcoholism

This report describes some significant new information coming out of modern research on the genetics of alcoholism. It is based on published research and personal interviews with prominent investigators in the field. Because of the prodigious amount of literature available, this booklet is particularly helpful since it summarizes the major highlights in 37 pages.

The National Clearinghouse for Alcohol Information, PO Box 2345, Rockville, Maryland 20852. No charge.

Other Books

"Give to the Winds Thy Fears:" The Women's Temperance Crusade, 1873-1874 — Jack S. Blocker, 1985. The author traces the Women's Temperance Crusade — the largest women's protest movement in 19th century United States — from its origins in public lectures by health reformer Dio Lewis, through its rapid spread across the nation, to its culmination in the Women's Christian Temperance Union. Greenwood Press, 88 Post Rd W, Box 5007, Westport, CT 06881. 280 p. $35. Contributions in Women's Studies, No 55. ISBN 0-313-24556-8.

Substance Abuse Book Review Index, 1984 — Jane Bemko, 1985. Contains citations for 226 titles together with an author index, subject index, title index, and a list of the journals searched. Marketing Services, Addiction Research Foundation, 33 Russell St, Toronto, Ontario M5S 2S1. 66 p. $8. ISBN 0-88868-112-7.

Over and Under the Table: The Anatomy of an Alcoholic — Kenneth Orvis, 1985. An autobiographical account of the author's struggle to accept and finally overcome his alcoholism. Optimum Publishing International Inc, Montreal. 162p. $12.95 paper. ISBN 0-88890-172-0.

The Yearbook of Substance Use and Abuse, Vol III — Leon Brill and Charles Winick (eds), 1985. Rethinking alcohol policy; the development of social controls over intoxicant use and their influence on social policy; the social context of an acute drug reaction; occupational alcoholism programs and female employees; a labor approach to alcohol and other substance abuse; a history of blacks and alcohol in United States politics; legalization of marijuana and year of birth; methadone maintenance in California; an ethnographic study of black drinking practices; the epidemiology of narcotic abuse among blacks in the US. Human Sciences Press Inc, 72 5th Ave, New York, NY 10011. 351 p. ISBN 0-89885-216-1.

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Saying No to Alcohol and Drugs

Number: 718.
Subject heading: Attitudes and values.
Details: 20 min.
Synopsis: In the 1984 Olympics, Valerie Brisco-Hooks won three gold medals in track and field. She explains different kinds of peer pressure that young people may face and suggests how to deal with each one. Scenes show children acting out the suggested responses to peer pressures: "friendly" pressure, "I dare you" pressure, "indirect" pressure, and finally, "heavy" pressure. Valerie discusses why people start using drugs and reviews how children can say no to pressure.
General evaluation: Good to very good (4.5). This film illustrates good methods for dealing with peer pressure. It is well-produced and a good teaching aid.
Recommended use: With a resource person, this film would benefit those eight to 12 years of age.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

Something to Celebrate

Number: 724.
Subject heading: Fetal alcohol syndrome: Native people.
Details: 28 min.
Synopsis: Mary and Bill, a young Native couple (see Projection 725) have just learned that Mary is pregnant and are planning to celebrate this evening. Mary goes to the local clinic where the nurse, Jean, shows her pictures of children born to mothers who drank while they were pregnant and warns her of the dangers. At home, Mary tries to explain to Bill why she will not drink. Bill starts to go out with friends to celebrate, changes his mind, and comes back to tell Mary he will wait until after the baby is born.
General evaluation: Fair to good, (3.5). This film has good information and portrays a realistic situation. However, the group had some concerns that parts seemed contrived.
Recommended use: With a resource person, this film could be useful with young, Native couples.

A Hit for Mike

Number: 725.
Subject heading: Solvents: Native people.
Details: 28 min.
Synopsis: This film opens with a scene of Native boys stumbling around in a field. Mike, one of the group, wanders away and falls in front of a pick-up truck, almost getting hit. Bill and Mary (see Projection 724) rush Mike to the clinic, where the nurse identifies the problem as the result of gasoline sniffing. Bill and Mary go to the referral centre to learn how they can help Mike. The head of the centre urges them to get Mike involved in baseball again. Bill and Mary enlist the aid of a tribal elder to talk to Mike. The elder tells Mike ways to feel good without sniffing gasoline and teaches him to whittle. Mike finally decides to join a baseball team and tells his younger brother about the dangers of sniffing.
General evaluation: Good (4.2). This realistic portrayal of gasoline sniffing by Native youth could lead to good discussion about the problems caused by and treatment for gasoline sniffing.
Recommended use: With a resource person, this film could benefit young, Native people.

The Haight-Ashbury Cocaine Film

Number: 726.
Subject heading: Cocaine.
Details: 35 min.
Synopsis: Cocaine has been used for 5,000 years as a stimulant, appetite suppressant, and energy booster. Today, cocaine use causes many problems. As users tell their stories, computer-generated graphics are used to illustrate the effects of cocaine. From their experiences, it appears that recovery is very difficult.
General evaluation: Very good to excellent (5.7). This well-produced film has good information about cocaine and its effects. Especially noteworthy are the graphics. General broadcast is recommended.
Recommended use: With a resource person, this film would benefit audiences aged 12 years and more.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Management II for Supervisors in the Health Care Setting — March 24, Toronto, Ontario. Information: Ingrid Norrish, director, professional and management development, Humber College, Box 1900, Etobicoke, ON M9W 5L7.

Making a Difference: Managing Workplace Pressures in Health Care — April 3-4, Mississauga, Ontario, May 1-2, Toronto, Ontario. Information: Mary B. Benedetti, program manager, professional and management development, Humber College, Professional Services, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

What an Employer Needs to Know to Make an Effective Intervention — May 7-9, Toronto, Ontario. Information: Intervention Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

National Consultation on Women and Drugs — May 12-15, Geneva Park, Ontario. Information: K. Madden, health promotion directorate, Health and Welfare Canada, Rm 449, Jeanne Mance Bldg, Tunney's Pasture, Ottawa, ON K1A 1B4.

Youth and Drugs, PRIDE CANADA Conference — May 22-24, Saskatoon, Saskatchewan. Information: Eloise E. Opheim, PRIDE CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Ontario Association of Professional Social Workers Annual General Meeting and Provincial Conference — May 29-31, Waterloo, Ontario. Information: OAPSW, 410 Jarvis St, Toronto, ON M4Y 2G6.

Ontario Medical Association 106th Annual Meeting — June 9-12, Toronto, Ontario. Information: Annual Meeting Coordinator, OMA, 250 Bloor St E, Ste 600, Toronto, ON M4W 3P8.

77th Annual Conference of the Canadian Public Health Association — Health Promotion Strategies for Action — June 16-19, Vancouver, British Columbia. Information: CPHA, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

Summer School for Addiction Studies — July 7-25, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

27th Annual Institute on Addiction Studies — July 13-18, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Dynamics of Social Change: Implications for Safety — July 29-Aug 1, Edmonton, Alberta. Information: Herb M. Simpson, Traffic Injury Research Foundation of Canada, 171 Nepean St, Ste 600, Ottawa, Ontario K2P 0B4.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

United States

PRIDE 1986 International Conference on Drugs — March 18-22, Atlanta, Georgia. Information: PRIDE (National Parents' Resource Institute for Drug Education, Inc), 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

Addiction on the New Frontier — March 27-29, Anchorage, Alaska. Information: Milam Recovery Centers, Inc, 14500 Juanita Dr NE, Bothell, Washington 98011.

SECAD-West — Current Trends in Addiction — April 2-6, Denver, Colorado. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, Addictive Disease Division, 11050 Crabapple Rd, Ste D-120, Roswell, Georgia 30075.

American Medical Association 7th National Conference on the Impaired Physician — April 10-13, Chicago, Illinois. Information: American Medical Association, 535 N Dearborn St, Chicago, IL 60657.

NCA Annual Conference — April 18-21, San Francisco, California. Information: National Council on Alcoholism, 12 W 21 St, New York, NY 10010.

American Medical Society on Alcoholism and Other Drug Dependencies and the Research Society on Alcoholism — Joint Meeting — April 18-22, San Francisco, California. Information: AMSAODD-RSA Meeting, 12 W 21st St, New York, NY 10010.

3rd National Conference on Alcohol and Drug Abuse Issues in Higher Education — April 27-29, San Antonio, Texas. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St NW, #181, Washington, DC 20001.

NECAD 86 — May 4-7, Newport, Rhode Island. Information: Jane Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Rd, Newport, RI 02840.

The National Association of Alcoholism Treatment Programs 8th Annual Meeting — May 6-9, Anaheim, California. Information: NAATP, 2082 Michelson Dr, Ste 304, Irvine, CA 92715.

American Psychiatric Association Annual Meeting — May 10-16, Washington, DC. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

1986 National Association of Social Workers National Conference on Women's Issues — Dangers and Opportunities: What's Ahead for Women? — May 28-31, Atlanta, Georgia. Information: NASW conference planning committee, 7981 Eastern Ave, Silver Spring, Maryland 20910.

International Drug Development in the 21st Century — 22nd Annual Meeting, Drug Information Association — June 1-5, Washington, DC. Information: Drug Information Association, PO Box 113, Maple Glen, Pennsylvania 19002.

American Society of Hospital Pharmacists — June 1-5, Denver, Colorado. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

Sage Conference: Preventing Relapse in Addiction — June 9-11, Adrian, Michigan. Information: Miriam M. Stimson, director, graduate studies, Siena Heights College, 1247 E Siena Heights Dr, Adrian, MI 49221-1796.

48th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 16-18, Tahoe City, California. Information: Mary Jeanne Kreek, Committee on Problems of Drug Dependence, Inc, The Rockefeller University, 1230 York Ave, New York, NY 10021.

37th Annual Symposium on Alcoholism — June 16-27, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

17th Annual Narcotic Research Conference — July 6-11, San Francisco, California. Information: E.L. Way, dept of pharmacology, University of California, San Francisco, CA 94143.

North American Congress on Alcohol and Drug Problems — Sept 7-11, Boston, Massachusetts. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St NW, #181, Washington, DC 20001.

Abroad

15th International Institute on the Prevention and Treatment of Drug Dependence — April 6-11, Amsterdam/Noordwijkerhout, The Netherlands. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

2nd Annual International Industrial Alcoholism Symposium — May 20-22, Frankfurt, Germany. Information: Annette Stappert, conference coordinator, Conecta, 12 Stooter St, 4330 Mulheim 13, Germany.

32nd International Institute on the Prevention and Treatment of Alcoholism — June 1-6, Budapest, Hungary. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

3rd Congress of the International Society for Biomedical Research on Alcoholism — June 8-13, Helsinki, Finland. Information: Sari Salo, 3rd ISBRA Congress, Alko Ltd, PO Box 350, SF00101, Helsinki, Finland.

International Symposium on Health Education in Schools —July 6-10, Jerusalem, Israel. Information: D. Tamir, International Symposium, PO Box 394, Tel Aviv 61003 Israel.

International Sociological Association World Congress — August 13-18, New Delhi, India. Information: Alex C. Michalos, University of Guelph, Guelph, Ontario, N1G 2W1.

14th International Cancer Congress — Aug 21-27, Budapest, Hungary. Information: Crimson Travel Service, 39 John F. Kennedy St, Cambridge, Massachusetts 02138.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

10th International Conference on Alcohol, Drugs and Traffic Safety — Sept 9-12, Amsterdam, The Netherlands. Information: Symposium Secretariat, QLT, Convention Services, Keizersgraacht 792, NL-1017 EC Amsterdam.

International Symposium on Young Drivers' Alcohol and Drug Impairment: Selective Countermeasure Program Development — Sept 13-15, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

Rules for the road: Canada's DWI legislation

TORONTO — Last December, the federal government enacted a broad package of reforms in Canada's drinking and driving laws. The amendments have created several new drinking and driving offences, provided tougher penalties, and introduced procedures to assist police enforcement. This report on the major features of Canada's federal drinking and driving legislation, including the December amendments, has been condensed from Robert Solomon's book Drug and Alcohol Law for Canadians, *published by Ontario's Addiction Research Foundation. Mr Solomon is a professor in the faculty of law, University of Western Ontario, London. The areas highlighted in blue relate to the new legislation on driving while impaired (DWI).*

The importance of Canada's drinking and driving laws cannot be overemphasized.

First, drinking and driving is the largest single criminal cause of death in Canada. In 1981, an average of seven people were killed, and 160 were injured *a day* in automobile accidents in which at least one driver had violated the federal drinking and driving laws.

Second, enforcing the federal drinking and driving law places heavy demands on the criminal justice system. For example, in 1982, Canadian police laid more than 167,000 drinking and driving charges.

Third, short of staying off the roads, it is impossible to avoid the risks posed by drinking drivers. It has been estimated that on certain nights of the week in North America, as many as 20% of drivers have been drinking, and 10% are impaired.

On December 4, 1985, the federal government enacted a broad package of reforms in the drinking and driving laws. The amendments retained the basic structure of the old legislation, but created several new drinking and driving offences, provided a broader and tougher range of penalties, and established procedures to assist the police in enforcement. I will discuss five types of drinking and driving offences:

- operating or having care or control of a motor vehicle while one's ability to operate the vehicle is impaired by alcohol or another drug;
- impaired or dangerous operation of a motor vehicle causing death or bodily harm;
- operating or having care or control of a motor vehicle with a blood alcohol level (BAL) in excess of 0.08%;
- failing to provide breath or blood samples for analysis; and,
- operating a motor vehicle while disqualified.

Several other criminal offences can apply to drinking drivers, including failing to stop at the scene of an accident and dangerous driving. Some important provincial laws also govern alcohol consumption and drinking and driving. These laws which regulate highways, licensing of drivers, and alcohol consumption, have a major impact on the enforcement of federal drinking and driving laws.

The scope

Many people assume they must be driving a car on a public road to be charged with a drinking and driving offence. One can also be charged while sitting on a snowmobile parked on one's own land. Three common elements of the legislation contribute to its broad scope:

- **Location** — Drinking and driving offences can occur anywhere. Drivers have been convicted when found on their own property, a vacant lot, or the property of a third person.

THE BACK PAGE

- **Definition of the term "motor vehicle"** — Drinking and driving offences apply to any "motor vehicle." The Criminal Code defines this term as any vehicle, except a train, that is driven by any means other than muscle power. Included are motorcycles, motorized bicycles, snowmobiles, all-terrain vehicles, golf carts, tractors, and even self-propelled lawnmowers.
- **Definition of the term "care or control"** — A person can be convicted of a drinking and driving offence not only when actually driving, but also when having "care or control" of a motor vehicle. Canadian courts have defined "care or control" broadly to include any act involving the use of a vehicle, its fittings, or its equipment. If one is found in a vehicle with the ignition keys, or near a vehicle in circumstances suggesting that one intends to drive, that person will likely be held to have had "care or control."

The offences

Impaired operation of a motor vehicle — Section 237(a) of the Criminal Code states: *Everyone commits an offence who operates a motor vehicle . . . or has the care or control of a motor vehicle . . . whether it is in motion or not, while his ability to operate the vehicle . . . is impaired by alcohol or a drug . . . .*

The key question is whether one's ability to operate a motor vehicle has been impaired by alcohol or another drug, not whether one is driving in a careless or dangerous manner. Also, the amount of alcohol or other drugs consumed is not important.

The Criminal Code does not define the word "impaired." This task has been left to the courts, and they have defined the word broadly. Usually, the courts try to determine whether the driver had complete control of the vehicle. It is not essential that the driver be visibly intoxicated or drunk.

Police often rely on their own observations in deciding whether a person is impaired. The manner in which the vehicle was being driven, the strong odor of alcohol on the driver's breath, slurred speech, dilated pupils, lack of coordination while producing a driver's licence or getting out of the vehicle, clumsiness in walking, slow or inappropriate responses to questions, and similar factors may all provide evidence of impairment. The police often ask the driver to take a series of coordination tests. A driver isn't required to take the tests, and refusals cannot be used against the driver. However, once the tests are conducted, the driver's performance can be used in evidence along with the officer's other observations.

Canadian courts have held that it doesn't matter whether the accused's impairment is due to alcohol alone, other drugs alone, or a combination of both alcohol and other drugs.

Impaired or dangerous operation of a motor vehicle causing death or bodily harm — Prior to December 4, 1985, drunk drivers who caused fatal accidents were often only convicted of one of the less serious offences, such as impaired driving or having a BAL in excess of 0.08%. Police seldom charged drivers with the more serious offences of criminal negligence causing death, criminal negligence causing bodily harm, or criminal negligence in the operation of a motor vehicle.

This problem, coupled with increased public concern about the deaths and injuries attributable to drinking and driving, led to the introduction of two new offences — impaired or dangerous operation of a motor vehicle causing death (Section 239[3]), and impaired or dangerous operation of a motor vehicle causing bodily harm (Section 239[2]). Courts have broadly defined the concept of impairment, making this element of the offence relatively easy to establish. In addition, it is necessary to prove the driver's impairment caused death or harm.

With the enactment of these offences, the federal government repealed the offence of criminal negligence in the operation of a motor vehicle. The offences of criminal negligence causing death and criminal negligence causing bodily injury were retained, because they are broad in scope and encompass many other situations aside from drinking and driving.

Driving with a BAL in excess of 0.08% — Section 237(b) of the Criminal Code states: *Every one commits an offence who operates a motor vehicle . . . or has the care or control of a motor vehicle . . . whether it is in motion or not . . . having consumed alcohol in such a quantity that the concentration thereof in his blood exceeds 80 milligrams of alcohol in 100 millilitres of blood.*

This criminal offence is based on the quantity of alcohol in the blood. The way one drives makes no difference. Similarly, it does not matter whether one is visibly intoxicated or one's driving ability is impaired. A BAL of 0.08% is a convictable offence.

The amount of alcohol one would have to consume to have a BAL in excess of 0.08% varies from person to person. It depends upon such factors as the percentage of body fat, the person's weight, when the person last ate, and the speed at which that person's body metabolizes the alcohol.

It is important to keep the concern about an exact BAL in perspective. Even if a BAL is below 0.08%, one can still be charged with the offence of "driving or having care or control of a motor vehicle while impaired."

There are basically two kinds of machines used to analyze breath samples — a Breathalyzer and a roadside screening device such as an Alcohol Level Evaluation Road Tester (ALERT). An ALERT machine is used to screen drivers. Those who fail an ALERT test are taken to a police station to have a Breathalyzer test or are held until a mobile Breathalyzer van arrives.

Refusal or failure to provide a breath or blood sample — The Criminal Code authorizes police to demand breath or blood samples from a motorist in three situations.

First, Section 238(2) permits an officer to demand an ALERT breath sample from a driver the officer reasonably suspects has consumed alcohol. Officers need not believe that one is drunk, impaired, or committing any offence. The officer may then demand a breath sample for analysis.

Second, Section 238[3](a) provides officers may demand breath samples for Breathalyzer analysis from any driver they have reasonable and probable grounds to believe is committing, or has committed within the last two hours, the offence of operating a motor vehicle while impaired by alcohol, or driving with a BAL in excess of 0.08%.

Third, as a result of the recent amendments, Section 238[3](b) permits the police to demand blood samples from drivers in certain, limited circumstances. This amendment was prompted by concern that some intoxicated drivers who were incapable of providing breath samples were escaping criminal liability. In order to demand a blood sample, the officer must have reasonable and probable grounds to believe the driver is committing, or has committed within the last two hours, either the offence of operating a motor vehicle while impaired by alcohol or the offence of operating a motor vehicle with a BAL in excess of 0.08%. The officer must also have reasonable and probable grounds to believe the driver is incapable of providing a breath sample or that it is impractical to obtain a breath sample. Moreover, the blood sample can only be taken by or under the supervision of a doctor, who is satisfied the procedure will not endanger the driver's life or health.

The new amendments also create a special search warrant which authorizes the taking of blood from drivers who are incapable of responding to a demand for a blood sample. These special search warrants are only available if the driver has been involved in an accident that has resulted in death or bodily harm.

It is a criminal offence to refuse an officer's demand for a breath or blood sample, or to refuse to accompany the officer for this purpose, unless the driver has a reasonable excuse. The offence is failure to comply with the officer's demand. The legislation provides one cannot be convicted for refusing to provide samples if one has a "reasonable excuse." This term is not defined in the legislation, and therefore the courts have been required to determine what constitutes a reasonable excuse.

The Canadian Bill of Rights provides that once arrested or detained, a person has a legal right not to be denied an opportunity to contact a lawyer. The Supreme Court of Canada has held that a driver taken into police custody for the purpose of having a Breathalyzer test *is* arrested or detained, and thus has a right to contact a lawyer.

Operating a motor vehicle while disqualified — Section 242(4) of the Criminal Code now makes it an offence to operate a motor vehicle if disqualified or prohibited from driving by a court, or if disqualified or subject to a licence suspension imposed by provincial law.

The penalties

The new amendments to the Criminal Code substantially increased the penalties for most of the pre-existing offences, established heavy penalties for the newly created offences, and gave judges the power to impose lengthy driving prohibitions on offenders.

The Criminal Code clearly provides that those convicted of a second drinking and driving offence are to receive heavier minimum penalties than first offenders.

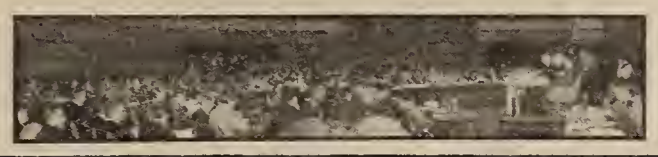
The federal drinking and driving legislation

Offences	Maximum penalties
Manslaughter	Life imprisonment; life prohibition from driving
Criminal negligence causing death	Life imprisonment; life prohibition from driving
Criminal negligence causing bodily harm	10 years' imprisonment; 10 years' prohibition from driving
Dangerous or impaired operation of a motor vehicle causing death	14 years' imprisonment; 10 years' prohibition from driving
Dangerous or impaired operation of a motor vehicle causing bodily harm	10 years' imprisonment; 10 years' prohibition from driving
Impaired operation of a motor vehicle; operating a motor vehicle with a BAL in excess of 0.08%; failing to provide a breath sample on an ALERT or Breathalyzer	**Summary conviction:** $2,000 fine; six months' imprisonment; three years' prohibition from driving **Indictment:** unlimited fine, five years' imprisonment; three years' prohibition from driving **Minimum (summary or indictment):** 1st: $300 fine; three months' prohibition from driving. 2nd: 14 days' imprisonment; six months' prohibition from driving. Subsequent: three months' imprisonment; one year's prohibition from driving
Failing to provide a blood sample	As above
Operating a motor vehicle while disqualified by the court or while one's licence is suspended	**Summary conviction:** $500 fine, six months' imprisonment; three years' prohibition from driving. **Indictment:** two years' imprisonment, three years' prohibition from driving
Failing to stop, identify oneself, and assist at the scene of an accident with the intent to escape criminal or civil liability	**Summary conviction:** $500 fine; six months' imprisonment; three years' prohibition from driving **Indictment:** two years' imprisonment, three years' prohibition from driving
Dangerous driving	**Summary conviction:** As above. **Indictment:** five years' imprisonment; three years' prohibition from driving

Betel-nut chewing in Toronto — a popular pursuit

p5

The Back Page:
Cynicism, idealism, and the future



Alcohol in paradise — Fiji starts to hurt

p7

Vol. 15 No. 4 2nd Class Mail Reg No. 2776 TORONTO, April 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Health chiefs want coordinated drug policies

By Anne MacLennan

LONDON — A crash course on international drug problems has led health ministers or their deputies from 30 countries to issue a joint call for new and more concerted action against drugs — both within countries and globally.

The senior health officials — from a range of countries, including drug-consuming as well as producing and transit nations — met here for three days in March at the invitation of Britain's minister of state for health and the World Health Organization (WHO).

The subject: action on the health aspects of narcotic and psychotropic drug misuse.

It is believed to be the first time national health ministers have met to focus on a specific problem area, and it is certainly the first time they've met to examine drug problems.

Despite the invitation and private pressure to attend, Canada's Minister of Health and Welfare Jake Epp declined; the delegation was lead by David Kirkwood, deputy minister. Other delegation members were Denys Cook, PhD, director general, drugs directorate, Health Protection Branch, and R.A. (Ron) Draper, director general, Health Promotion Directorate, both of Health and Welfare; and H. David Archibald, long-time consultant on drug affairs to the WHO and the United Nations, and president of the Switzerland-based International Council on Alcohol and Addictions.

To brief the ministers — in some cases, if not most, cabinet ministers have little knowledge of the breadth and depth of the impact of drugs — the WHO commissioned a set of seven background documents from experts around the globe.

The papers covered epidemiology and trends in drug misuse and related health problems; prevention and treatment; the making of a national drug abuse control policy; international collaboration on drug-related health problems; administrative and legal measures linked to international conventions; a summary of WHO's policy, strategies, and programs, and its responsibilities under the drug control treaties; and, developing national responses to drug-related health problems. (The paper on international collaboration was prepared by Mr Archibald.)

At the end of the meeting, the ministers agreed that "not only does misuse (of drugs) cause suffering to individuals; but also, societies as a whole bear great health and social costs . . . ."

They called on participating countries to:

- continue efforts to develop coherent national policies for prevention, treatment, and rehabilitation, and to involve mechanisms which will allow coordination of work of all the relevant sectors of government;
- improve information systems providing data on the epidemiology and trends of drug misuse;
- make comprehensive assess-

(See Treaty, page 2)

Physical condition of street kids shocks Senate youth committee

By Joan Hollobon

TORONTO — Absolutely nothing," prepared Canada's Special Senate Committee on Youth for its face-to-face meetings with the young Canadians who appeared before it.

Senator Lorna Marsden told a symposium on street youth here the young people, rich and poor, showed "courage and optimism and belief in the country," despite "very real and substantial problems," especially the lack of jobs.

Social, health, legal, drug, and educational difficulties make it hard for the young and inexperienced to get jobs that do open up.

But, it was the physical differences between college kids and street kids that gave the committee the greatest sense of urgency, she said.

"All of them had problems and troubles. But, the high school and college kids were big and physically healthy, with good teeth, strong limbs, and all those manifestations of having been well-nourished.

"And, the street kids were so small and undernourished and with little energy, and were more likely to be smoking.

"In some cases, it was very dramatic — I couldn't believe my eyes. . . . Not only was the physical difference just stunning — they are all young Canadians, all the same age — but they didn't even look at one another. There didn't even seem to be any sense of camaraderie or any sense there was some connection between them. And, it was frightening," she said.

Instability in home lives seemed to have a particularly high correlation with the experiences of the young in school or on the street.

Regardless of wealth or poverty, those with parents interested in them — even if the parents were not living together — or who had some kind of stability at home, had hope. Those who seemed most lost or hopeless, whether they had university education or no education at all, were those who said their parents "didn't care," didn't know their families, or had several adoptive homes.

"I have been appalled to hear parents say they kicked their sons — more than daughters — out of their homes because the children couldn't get jobs. Most of the young people genuinely can't get jobs. Parents are foisting their own anxieties and values on young people and punishing them if they can't or won't conform," said Senator Marsden, chairman of **The Journal**'s editorial advisory board.

Marsden: differences stunning

New needles: another AIDS issue in UK

By Alan Massam

LONDON — Scottish health experts are debating whether intravenous drug addicts should be supplied with new syringes to help prevent the spread of AIDS (acquired immune deficiency syndrome).

The issue arose following a study by Edinburgh family physician Roy Robertson which indicated more than 50% of the hard drug addicts in his practice area showed evidence of exposure to the AIDS virus (**The Journal**, February).

The statistic shocked communicable disease experts in England who had previously believed the virus was only affecting about 2% of the addict population. Dr Robertson was given a grant to help stop the spread of the virus in the subdivision of Edinburgh and is now issuing new syringes to addicts there who apply for them.

A spokesman here for the Scottish Office told **The Journal**, however, that to issue new syringes to addicts, while at the same time trying to prevent the spread of addiction, is not an easy decision to make.

He said an advisory group, including Dr Robertson, has been set up to advise on ways to contain the AIDS virus.

It is feared that because many addicts are also prostitutes, there is a considerable risk they will spread the virus to the general population. The Scottish advisory group has recently completed a study tour of Amsterdam where addicts are issued new syringes to prevent them sharing in so-called shooting galleries.

Donald Acheson, MD, chief medical officer, department of health and social security, which is responsible for health care in England and Wales, is clearly concerned about the high incidence of exposure to the AIDS virus among Scottish addicts.

He told a Newcastle conference there is an urgent need to discover why so few addicts had been infected with AIDS in Amsterdam while so many are affected in Edinburgh.

The Scottish shooting galleries appeared in Edinburgh after police started using syringes as evidence to convict drug dealers.

INSIDE

NEWS

Briefly ...

High-tech guru

HALIFAX — Former guru of the psychedelic drug scene, Timothy Leary, has rephrased his teachings. After stints with hallucinogens, prison, and even stand-up comedy, Dr Leary now peddles computer software with the zeal he once used to endorse better living through chemicals, says *Canadian Press*. Instead of "Turn On, Tune In, Drop Out," his advice to the Yuppie set has become "Turn On, Tune In, and Reboot."

Smokeless skies

HALIFAX — Canadian military crews flying anti-submarine patrols have been told to butt out their cigarettes, says *Canadian Press*. A memo from Brigadier-General Ian Patrick, commander of the Maritime Air Group, says smoke affects mental alertness of air crew members. The Department of Defence is concerned also that cigarette smoke may adversely affect computers and sensitive monitoring devices in airplanes.

Warnings warning

TORONTO — Signs warning motorists not to drink and drive may drive people to drink. A one-year study of traffic mishaps in the vicinity of four warning signs here shows that more alcohol-related accidents occurred after the signs were installed than before, says *The Globe and Mail*. The signs were posted in the Beaches area.

GPs' tranq training

LONDON — Doctors who are short of time are being criticized here for over-readiness to hand out repeat prescriptions for tranquillizers. The allegations are being made by Labour Members of Parliament who are calling for the implementation of a World Health Organization recommendation on tighter scheduling. One MP, says *Doctor*, wants more money spent on training general practitioners on the problems of long-term use of tranquillizers.

Hatless in Harare

HARARE, Zimbabwe — Iranians attending a state banquet here walked out on the festivities because alcohol was served and women attended bare-headed, says *Associated Press*. Despite the honored guests' mass walk-out, the band played on.

Hospital blunders

TORONTO — Wrong drugs are given to patients about 65 times a day in a hospital with 500 beds, a coroner's inquest has been told here. Michael McGuigan, MD, an expert on medication errors, said mistakes are made in 10% to 12% of the cases in which drugs are administered in North American hospitals. Dr McGuigan was testifying at an inquest into the death of a patient whose body showed traces of digoxin, although the heart drug had not been prescribed, says *The Globe and Mail*.

Ross Ramsey appointed president

Kaiser to open drug program in BC

By Maureen Brosnahan

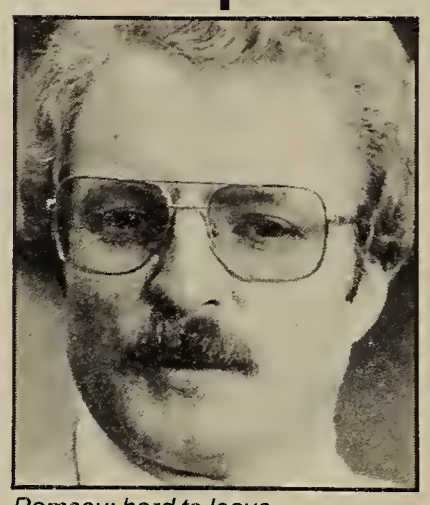
WINNIPEG — The executive director of the Alcoholism Foundation of Manitoba (AFM) here, is leaving to become president of a new, private substance abuse foundation in Vancouver.

Ross Ramsey, executive director of the AFM since 1983, has been appointed president of the Kaiser Substance Abuse Foundation.

The new foundation was established by James Edgar Kaiser, president of the Bank of British Columbia and chairman of the Kaiser-Permanente Health Maintenance Organization in the United States.

Mr Kaiser is now a Canadian citizen who resides in Vancouver.

Provincial Court Judge Charles Rubin, chairman of the AFM, said Mr Ramsey's departure will be a loss to Manitoba.



Ramsey: hard to leave

"He's probably one of the top two or three professionals in this field in Canada. It's going to be very difficult to fill his shoes, especially in this time of restraint.

"We don't offer the most attractive salary in Canada," Judge Rubin added.

Mr Ramsey said he's sorry to be leaving Manitoba. He had worked for the AFM in the 1970s before moving to Alberta and back here in 1983 to become executive director.

"It's hard to leave," Mr Ramsey said. "But, the new foundation, which is being funded by Mr Kaiser and others in the private sector, is an initiative that has never been tried in Canada."

Mr Ramsey said Mr Kaiser, who has contributed $2 million to the new project, has had a special interest in substance abuse as part of preventive health care because of earlier problems within his family.

Mr Ramsey said he will commute between Vancouver and Winnipeg to help with the transition at AFM.

Judge Rubin said advertisements are out for a new executive director and he hopes to fill the position by the summer. He's confident the top-level administration Mr Ramsey established during his term can handle the transition period.

The AFM, which deals with alcohol and chemical abuse, provides counselling, residential, and educational programs throughout Manitoba. It is operated as an arm of the provincial health department and last year had a budget of about $9 million.

Canadian kids drinking to get drunk

By Terri Etherington

OTTAWA — When young people drink, they drink to get drunk.

This approach to alcohol by young people was one of the most disturbing findings in a survey of Canadian youth on their health attitudes and behaviors, says senior researcher Alan King, PhD.

Two of every five 15 year olds drink at least twice a month and, of those, one-third typically drink five or more drinks at one sitting, said Dr King, director, social program evaluation group, Queen's University, Kingston, Ontario. With colleagues at Queen's, Dr King conducted the survey for Health and Welfare Canada.

"This appears to be a common approach to drinking by young people," Dr King told **The Journal**.

The survey asked 33,111 young people aged nine, 12, and 15 years about health habits, including nutrition, leisure activities, safety, peer influence, mental health, parent-child relationships, and self-esteem. The two older groups were asked about sex education and alcohol and other drug use.

Another concern, said Dr King, was the widespread difference in drug-use patterns from province to province.

King: common approach

The report indicates alcohol use by grade 10 students (15 year olds) ranged to a high of 71.1% in one province from a low of 55.1% in another. For grade seven students (12 year olds) alcohol use ranged to 20.9% from 13.3%.

For grade 10 smokers, provincial differences ranged to 36.3% from 19.9%.

The proportion of grade seven users of cannabis was about the same from province to province. By grade 10, however, the percentages ranged to 22.2% from 10.8%.

These differences, Dr King said, "suggest different types of reinforcement, reflecting different social and economic circumstances. This came through clearly."

An agreement with the provinces prevents Dr King from disclosing details of provincial statistics, but the research team and representatives from Health and Welfare are touring the provinces discussing results and comparing them to the national averages.

Elaine Cameron, health education consultant, Health Promotion Directorate, Health and Welfare, said workshops across the country will allow policy makers and program planners to react to specific results for their province.

Meetings have already been held in the four western provinces with an Ontario workshop scheduled for April, the Yukon and the North West Territories in May, and Quebec and the Maritimes in June, Ms Cameron told **The Journal**.

The study says there is a "clear, common pattern of risk-taking attitudes and behaviors."

Winnipeg youths outdrink average

By Maureen Brosnahan

WINNIPEG — Young people here are more likely to drink once a month and use marijuana but are less likely to smoke than their counterparts across Canada, a recent survey indicates.

The study of 501 people between the ages of 12 and 17 years was conducted by the Alcoholism Foundation of Manitoba (AFM) and the provincial health department.

It found 31% of those surveyed said they consumed at least one drink a month, compared to the nation average of 27%. (See story above).

As well, 24% of those surveyed said they have used marijuana, compared with 21% nationally. However, 18% of those in Winnipeg said they were daily smokers compared to 21% across Canada.

The survey found those between 15 and 17 years were more likely to indulge in alcohol and marijuana than the 12 to 14 year olds.

It also found boys were more likely to drink than girls — but the girls were more likely to be smokers.

Denise Koss, AFM prevention consultant, said most of the figures did not significantly differ from those in the national studies.

However, Ms Koss said she was concerned by some comments by young people who admitted using alcohol and marijuana regularly. Of those, 25% said their use of the substances had caused problems in school, in relationships with family and friends, and with the law.

"Although actual numbers are small, they are significant," she said. "It does seem that regular use can lead to problems."

Gordon Barnes, PhD, head of the family studies department, University of Manitoba here, said the study results were not surprising.

"The overall figures are not all that bad, but I think that's because of the young people, the 12 to 14 year olds," said Dr Barnes.

He said the figures for the 15 to 17 year olds are likely substantially higher. Other studies suggest as many as 50% of people in that age group have tried marijuana, and 90% take a drink.

Ms Koss said the results of the survey are being examined and used by the AFM as a basis for planning and develping new education programs and new directions for counselling young people.

Treaty cooperation urged as health ministers meet

(from page 1)

ments of the need for treatment and rehabilitation and remedy any shortfalls in care provision;

- encourage and support community action to reduce the demand for drugs and make appropriate treatment and rehabilitation services available;
- contribute resources to stimulate international collaboration aiming to promote the rational prescription and controlled distribution of dependence-producing psychoactive substances; exchange information and experience, and undertake jointly research and training; and,
- cooperate in activities under the international conventions on psychoactive substances.

They also agreed national and international policies should recognize as basic principles that countries should cooperate and share information and experience; that action by one country can reinforce action taken by others and that the absence of action by a country reduces the chances of successful action by others; that drug misuse is part of a spectrum and much can be learned from experience gained in combatting problems related to misuse of such substances as alcohol; that action to reduce supply and demand are equally essential and should be complementary and integrated; that national policies on prevention and treatment are more likely to be successful if they are developed in a complementary way and are congruent with national and global strategies for Health For All by the Year 2000; and, that action must be taken by health ministers themselves and in collaboration with ministerial colleagues in areas such as law enforcement, education, and the environment.

— coming up in —

THE JOURNAL

- **Stats-facts on the elderly**

NEWS

Alcohol industry reps say ad controls adequate

Senate youth committee wants TV ads banned

By Joan Hollobon

TORONTO — The Liquor Licence Board of Ontario (LLBO) and the CRTC (Canadian Radio, Television and Telecommunications Commission) are reconsidering guidelines for television advertising of alcoholic beverages.

The independent reviews coincide with a recommendation by Canada's Special Senate Committee on Youth that all TV alcohol advertising be banned.

At present, only the advertising of spirits is banned, but guidelines exist on the use of "lifestyle" advertising for beer and wine.

In *Youth: A Plan of Action* published in February, the Senate Committee quotes reports that about two-thirds of Canadian high school students drink alcohol, with males, older students, those from higher-income groups, and those who are not regular church-attenders, drinking more heavily. It also notes, however, that overall alcohol consumption, which increased until the end of the 1970s, has shown a slight decrease since 1980.

"The advertising of alcohol and cigarettes, in which products are invariably linked with sexuality and the 'good' life, appears to have a powerful influence on young people," the Senate report states.

Spokesmen for beer and wine companies claim advertising is aimed at inducing drinkers to switch brands, not at increasing total consumption.

Dennis Manning, director of government affairs for Labatt's Ltd, quoted reports of research, including work done here at the Addiction Research Foundation (ARF), which suggests advertising has little effect on alcohol consumption or associated problems, such as drinking and driving.

Mr Manning also said a report from the Traffic Injury Research Foundation in Ottawa found no apparent relationship between "per adult consumption of alcohol and advertising" and "no evidence of a relationship between advertising and the extent of drinking and driving or alcohol-related crashes."

Statistics substantiate the industry's claim advertising is aimed at "corporate shift," Mr Manning said, since figures show that the three top breweries fight over market shift that can total $200 million in profits in four years.

"Every 1% of the market represents 60 million bottles of beer — that is approximately $10 million in profit," Mr Manning said.

In the past four years the shift has averaged 5%, to a total 20% in the period. Mr Manning: "If you take 20% . . . that's $200 million in profit — that's why we advertise."

David Diston, Ontario vice-president of Brights Wines Ltd, considers a ban unnecessary.

"I believe that properly enforced, the existing guidelines or regulations for television advertising ensure that we don't have lifestyle advertising," Mr Diston said.

But, what is "lifestyle" advertising?

Gary Megaffin, LLBO public relations officer, said there has never been a clear definition to guide the board.

Barry Tocher, the LLBO's new executive director, told **The Journal** the question of advertising was on the agenda for an upcoming board meeting. The entire board, however, was replaced in February.

Mr Tocher: "Banning advertising will be an option to consider in any sort of policy review, but, at the present time, there's no move to ban advertising other than to fall within the guidelines."

Although the industry claims advertising is successful only in achieving brand switching, Mr Tocher said the impact on youth is a valid concern.

Mr Tocher will propose that the new LLBO find out "what actually has been done in terms of trying to determine the effects of lifestyle advertising on people."

If the research proves deficient, the board might have to commission studies, but "we don't want to reinvent the wheel."

The CRTC sought public comment last October on regulations governing the advertising of alcoholic beverages as part of its regular review, Jeff Atkins, a CRTC spokesman, told **The Journal**.

At present, the CRTC must approve scripts for TV beer and wine ads. Approval is a joint procedure with the provinces, he said.

The CRTC expects to issue a formal, public statement this month (April).

BC moves methadone care to provincial clinics

By Heather Walker

VANCOUVER — A decision to remove methadone-prescribing privileges from private doctors and centralize treatment in provincial clinics here has raised concern addicts will find it more difficult to seek treatment and, in some cases, end up back on the street.

British Columbia health ministry officials say the decision was made because of fear there was not enough control of methadone distribution and because coroners' reports indicate some patients were mixing methadone with other drugs.

Gus Richardson, director of the health ministry's alcohol and drug division's support service, told **The Journal** he believes most of the concerns expressed by addicts are the result of their uncertainty about how the new program will work.

The centralization decision, he said, "was based on a recommendation by a joint committee of the BC Medical Association (BCMA), the BC College of Physicians and Surgeons, the BC College of Pharmacists, and the ministry of health.

"Then, each group had to take the recommendation back to their organization for agreement. That was done by about mid-December, and we weren't able to do any organization before. I think the people who contact us are scared because we haven't dotted all the i's and crossed all the t's yet."

The BC ministry already operates one methadone centre in Vancouver and others in Nanaimo, Campbell River, and Prince George. The Vancouver clinic currently treats almost 200 people. Two other clinics will be added to accommodate approximately another 400 former heroin users.

Mr Richardson said the program will be phased in gradually.

"Physicians' licences to prescribe methadone expire over the period up to October. We're planning for an orderly expiration of licences and an orderly transition."

Varnam: a different way

Ken Varnam, MD, one of six doctors here currently treating former heroin users with methadone (**The Journal**, July, 1985) and head of the BCMA's drug dependency committee, said although the BCMA agreed with the government plan, the joint committee tried to dissuade them.

Dr Varnam said the committee "wanted the provincial government to be more involved in drug treatment, but in a different way. We would have liked them to provide more medically oriented treatment clinics to get people off the street, to get them to the point where they could be treated by private doctors."

He said several of his patients are worried that going to clinics will put them back into contact with street life and with people they want to avoid. As well, former heroin users with stable jobs are worried they might lose their jobs if they have to take time off to go to the clinics or if employers learn about their addiction.

Mr Richardson said he is sympathetic to these problems, and the clinics will try to accommodate such needs.

"We want the clinics to be open from 6 am to 10 pm and on weekends to accomodate working people, and we want it to be by appointment so it won't be so impersonal and so people won't have to stand around waiting their turn."

Mr Richardson said the Vancouver methadone centre has had many calls from people concerned about the changes. He has handled about 35 calls at his Victoria office.

INSIDE OUT

A child of an alcoholic remembers

The friend in the office brought it back to me, opening up again a door I'd have sworn I had deliberately shut forever.

"Hey," he said, "I've got this neighbor, lives just across the street, an old guy, kind of with an accent. He's sort of an eccentric, but nice, you know? Well, we were talking, and he asked if I knew you. He'd seen your name, something you wrote once about your dad, and how you'd tried to chase down his whereabouts after you'd lost track of him for years.

"Anyway, I told him you lived just a couple of blocks away. He perked right up and said to tell you that anytime you want to go and find out something about your father, he'd be glad to talk to you. He knew him very well, he said. Liked him a lot too, says he was okay, a good man. He has a couple of your old man's pipes and would like to give them to you, if you want them. Something to remember your father by."

That was a long time ago. And, I've never yet gone to see the man who has my father's pipes, although, strangely enough, I remember exactly what they looked like, when I was a boy, and how they smelled (rather sweetly, actually). I remember, even, the teeth marks on them.

It's funny, in a macabre way, but those pipes are sometimes just about the only unchanging thing I can recall about my father. They're the aspect of him that is still almost tangible, and even now, when I'm at a party and see through the smoke another man holding a pipe, I briefly think of my dad.

And when I think more than briefly of him, which isn't often these days, I remember other things too. Awful things — ghostly visions that keep shifting and trembling, hiding their meaning behind scary veils.

I remember watching him and hearing his agony and the walls shaking as his body arched and banged against them, as the pain of gargantuan withdrawal seized him, as the hells of delirium tremens engulfed his soul, there, in the room next to mine. I was a frightened boy, uncomprehending, stupefied by his terror. *Why are you suffering so much, Dad? Is it something I did? I don't know how to help you!*

The only difference between him and me is . . . I have time left to heal

And, I remember the endless fighting between him and my mother that would start in the kitchen and go on all night, with me sitting at the top of the stairs, shaking, coldly awake, wondering what it was all about. Then, the fighting would come upstairs, me now in bed, under the covers, pretending I was asleep. *Why do they argue all the time? Why do they never kiss each other?*

I remember my sister's growing rage at him always seeming to let her, his "princess," down.

I remember, dimly now, my own growing puzzlement: we didn't seem to be like the families my friends had. Something was missing, something mightily serious.

Later, I learned what was so serious, what was missing, in my family. Later, I found out — when I was a teenager — what was troubling my father so deeply.

But, if the word alcoholic registered, the meaning didn't. Then, he left, sent into exile, as it were, to become a rapidly fading blip, like a Caribbean storm slowly disappearing off the edge of a computerized weather chart.

So, I went on with my own life, cutting myself off as much as I could, determined never to be like my father.

For years, I forgot all about him. I never asked about him, didn't want to know. Even when I remembered some of the good things about him — and it was hard to do — I would shrug. As far as I was concerned, he was already dead.

But, something strange was happening to me, and I'm only aware of it now. As my own drinking habits increased, my curiosity about him increased. As the years went by, I could see, when a snake of honesty slithered through my massive Great Wall of evasion, that the parallels between me and my father were beginning to become eerily striking and too frightening to think about.

But by then, though of course I didn't know it, the hounds of heaven were after me. Waiting in the wings to tell me the news I'd been trying to avoid.

A few years ago, my curiosity became an obsession. What had happened to him? Where was he? Where was this man that I even looked so much like now, as I'd seen from an old photograph taken when he was my age? Had he come through? Had he stopped drinking?

I went looking with a vengeance, and I found out about him and his sad and desperate end and, defensively, I preened a little that at least he hadn't died on skid row somewhere. He'd had an okay apartment, at the end, and wasn't that just great? Even alcoholics — and he was drinking extremely heavily at the end, he was raving like the lunatic he literally had become — have some dignity, a little class. That's what I told myself.

Now, of course, I know the truth about his life, because it became my truth too, and I know a little about his suffering and his monumental losses. I know the areas where the deep pain gushed from, and the guilt, and the death of all his self-respect.

And sometimes, when I'm up all night, just thinking, at peace now, at last, I dearly wish he were still alive, still aware enough for me to say: "I know. I know."

Because the only differences between him and me — the only differences — are that I have time left to heal the still-broken parts, and I have hope. As long as I stay straight.

So, somehow, I think I will let his pipes stay exactly where they are.

Who says, after all, that we're supposed to get to know all of our neighbors?

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Drinking problems and aging

Aging has little influence on male drinking behavior says a study which looked at alcohol consumption among a group of Boston residents in 1973 and 1982. In 1973, 1,859 male volunteers between 28 and 81 years participated in the Normative Aging Study and described their drinking habits in questionnaires. In 1982, 1,713 of the same subjects responded to a similar questionnaire. Multivariate statistical analysis revealed older men drank significantly less than younger men at both times and reported far fewer problems related to drinking. But, there was no tendency of subjects to decrease their consumption levels over time. The researchers say their findings could have important public health implications in the United States. "Older men have for generations had the advantage of lower rates of drinking problems and alcoholism. If current trends continue, oncoming cohorts of older men will have sharply increased rates of drinking problems." They also note that even maintaining a life-long drinking habit for these men could be dangerous because of the greater susceptibility of the elderly to the effects of alcohol.
American Journal of Public Health, December, 1985, v.75:1413-1419.

Smoking increases risk of preterm births

An increased risk of early delivery faces pregnant women who smoke. Researchers in the epidemiology branch, United States National Institute of Child Health and Development, made this finding as part of a prospective evaluation of 30,605 pregnant women enrolled in the Northern California Kaiser-Permanente Birth Defects Study who received prenatal care between 1974 and 1977. All women who delivered a single infant of 24 or more weeks gestational age and weighing at least 500 grams were included in the study. From a questionnaire given in the first trimester of pregnancy, it was determined 13.3% of the women smoked one or more packs of cigarettes a day, while 14.6% smoked a lesser quantity. The researchers found preterm births (less than 37 weeks gestation) were 20% more common in the women who were heavy smokers, and this effect was strongest for births occurring before 33 weeks, in which case, these "very preterm" births were 60% more common in heavy smokers. In total, 4% of the preterm and 9% of the very preterm births in the study were attributable to smoking. Smoking was associated with both premature rupture of the membranes and placental complications. No consistent relationship was found between alcohol consumption and preterm birth. The significant relationship seen with smoking was not accounted for by any other factors studied. The researchers conclude: "Physicians who provide care for pregnant women who smoke have an added impetus to incorporate smoking cessation into prenatal care."
Journal of the American Medical Association, January 3, 1986, v.255:82-84.

Opiate toxicity and ASA

For the first time, researchers have reported cases of serious opiate toxicity following overdoses with over-the-counter pain killers containing acetylsalicylic acid (ASA) [eg Aspirin] and codeine. The Scottish report from the Regional Poisoning Treatment Centre, Royal Infirmary, Edinburgh, deals with two cases of patients who took 80 and 100 tablets respectively of drugs containing 300 milligrams ASA and 8 mg codeine per tablet. In both cases, the severe poisoning caused appreciable depression of consciousness and miosis, which were reversed by the opioid antagonist naloxone. This indicated the codeine rather than the ASA was responsible for the symptoms. Both patients recovered. The report notes the amount of codeine available in combination analgesics is usually not thought to be toxicologically important in the context of overdose. But, these cases illustrate how inappropriate treatment might have been started had the codeine not been taken into account. ". . . If the central depression had been attributed solely to intoxication with salicylate, hemodialysis might have been inappropriately begun because of the poor prognosis of coma induced by salicylate," the study says. The three physicians presenting the report note that because opiate toxicity is possible with combination pain killers containing ASA and codeine, depression of consciousness after taking these drugs should not be attributed solely to salicylate acidemia before a trial with naloxone is done.
British Medical Journal, January 11, 1986, v.292:96.

Rx drug files incomplete

Major inaccuracies in hospital and physician records of what drugs patients are taking have been identified as a possible factor in overprescribing. That's the conclusion of four British researchers at the General Infirmary, Leeds, who looked at what medication 59 consecutive patients attending the general medical clinic at the hospital were actually taking. They compared this with the drug regimen listed on the patients' charts at the hospital and in general practitioners' offices. The study found in 76% of cases the medication brought in by the patient for evaluation differed from the drug regimen listed in the hospital notes. This was true of 70% of the patients when the medication was compared with questionnaires completed by their physicians. For more than one patient in 10, there was a major error in drug treatment or omission in hospital records. The study found almost half of the patients were taking drugs in addition to those shown in their records. The researchers recommend the best way of finding out what drugs patients are taking is to ask them to bring in all their medications when visiting the physician.
British Medical Journal, January 11, 1986, v.292:99-102.

Pat Rich

Canadian reporting of AIDS to seek out IV drug addicts

By Kate Fournis

OTTAWA — Federal health officials are beginning to look specifically for AIDS (acquired immune deficiency syndrome) among Canadian intravenous (IV) drug addicts.

For more than two years, national AIDS statistics have shown only one case in the IV drug abuse category.

The apparent lack of such AIDS cases may be "an artifact of our reporting mechanism at the moment," says Gordon Jessamine, MD, chief of the field epidemiology division at the Laboratory Centre for Disease Control (LCDC) here.

The reason for fewer AIDS-infected Canadian addicts, by ratio, than in the United States may be because the Canadians, unlike their US counterparts, buy sterile needles and syringes over the counter.

But, some cases of AIDS in IV drug abusers may have been missed because of the wording of the current reporting forms, Dr Jessamine told The Journal.

The form that has been used asks doctors to indicate which risk groups their AIDS patients are from.

"I'm quite sure what happens is that, in many instances, physicians just pick the first one — male homosexuals and bisexuals are the first group on the list — and say, 'Ah, yes, that's where he is.' They don't ask about the others, and we never hear about them," Dr Jessamine said.

However, Canada's National Advisory Committee on AIDS is changing the reporting form so doctors will indicate all risk factors that apply to their patients.

"In other words, were they people who were involved in homosexual/bisexual practices?" he said. "Were they people who, in addition or besides that or apart from that, were into intravenous drug abuse?"

The likelihood that some AIDS patients have multiple risk factors was lent validity by a survey of prostitutes in Alberta and Vancouver.

"Of the prostitutes surveyed — none of whom were positive (for the AIDS virus antibody) — the number who had been involved in IV drug abuse was quite substantial. If any of them had become positive, I think we would have probably gone for IV drug abuse (as the risk factor) rather than heterosexual contact."

Until the new reporting forms are available — possibly this month — Dr Jessamine will be asking LCDC field epidemiologists to investigate a sample of AIDS patients still alive in each province to see if they have other risk factors in addition to their originally reported risk categories.

As of March, 514 AIDS cases (including 22 children) had been reported. Of the total, 249 have died (including 10 children).

New marketing techniques include 'free' needle offers

NEW YORK — Drug dealers here have adopted new marketing techniques to meet increased demand for sterile needles prompted by the AIDS (acquired immune deficiency syndrome) epidemic.

They are offering intravenous drug users two types of "free" sterile needles, say Don Des Jarlais, PhD, and William Hopkins of the New York State Division of Substance Abuse Services.

The first strategy is a two-for-one deal. Needle sellers include an extra needle with the sale of a complete syringe and needle, in packages stapled together, the officials said in a letter to *The New England Journal of Medicine* (December 5, 1985).

A new syringe with needle typically sells for $2, but the complete syringe with extra needle sells for just $2.50.

"The 'extra point' can be used immediately if the first needle becomes clogged when a drug user is preparing to inject," Dr Des Jarlais and Mr Hopkins wrote.

The second strategy is the inclusion of a "free" needle and syringe with sales of $25 and $50 bags of heroin — although this practice does not appear as widespread as the "extra point" sales, they added.

Health officials here have considered lifting the restriction on the sales of sterile needles as a way of preventing AIDS, but wonder whether intravenous (IV) drug users would readily use them.

"These two 'free needle' marketing tactics indicate an increased demand for clean needles among IV drug users in New York City and an effort by present suppliers to meet that increased demand," the state health officials said.

Earlier this year, a team of New York researchers noted that street sellers were repackaging used needles and selling them as new (The Journal, January).

Maryland physicians probe relationship

Type of stroke linked to alcohol use

SAN FRANCISCO — An association between alcohol intake and stroke has been confirmed by Baltimore researchers, but they are not yet sure what the relationship means or what, if any, role alcohol consumption has in the etiology of cerebrovascular disease.

Using data from the United States National Institute for Neurological and Communicative Disorders and Stroke (NINCDS), the University of Maryland physicians say the type of stroke suffered is related to alcohol consumption prior to the attack.

Results of the study were presented here by Gita Moorthy, MD, during a poster session at the 11th International Joint Conference on Stroke and Cerebral Circulation sponsored by the American Heart Association (AHA).

In the study, information on alcohol intake in the 24 hours prior to stroke was collected by questionnaire from 832 of 1,054 patients entered in the NINCDS Stroke Data Bank.

Of 645 patients with ischemic infarctions, only 5% reported having two or more drinks in the day prior to the attack. But, of the 73 patients with intracerebral hemorrhages, 18% had two or more drinks in the same period, and nine of these 13 patients reported having more than five drinks.

Other factors such as age, race, acetylsalicylic acid (eg Aspirin) use and/or other anticoagulant therapy, socio-economic status, hypertension, and 30-day survival were all the same in those who did and did not consume alcohol.

From these findings, the researchers conclude the ratio of intracerebral hemorrhage to ischemic infarction is increased in patients who have had two or more drinks in the previous 24 hours.

While this suggests an association between alcohol consumption and stroke type, it does not support the notion put forward by other researchers that the level of acute alcohol intake is associated preferentially with ischemic infarction.

Dr Moorthy was reluctant to draw any other specific conclusions from the study.

Quebec telethon targets treatment

MONTREAL — An appeal for funding for alcoholism treatment services and education will go to the public here this month, as the Fondation Jean Lapointe sponsors a nine-hour telethon designed to "demystify" the problems of alcoholism.

Jacques Perras, executive director of Maison Jean Lapointe, a 45-bed centre outside Montreal, said the Fondation, which operates the centre (The Journal, September, 1983) hopes to raise $1.5 million on the telethon slated for Sunday, April 6.

The program, to be aired on a provincially-owned television station, will be hosted by Jean Lapointe, Quebec singer-comedian and recovered alcoholic for whom the centre is named. Each hour, 10 minutes of live and taped interviews will examine alcohol-related problems.

Funds will be used to support Maison Jean Lapointe, to open a second, smaller centre in the Quebec City area, to support other small, struggling centres, and to disseminate information.

Mr Perras told The Journal there is a "dire lack" of information on the problem in Quebec. In the last two years, there have been only two small pamphlets from the government, he added.

"The picture of alcoholism in Quebec is that there is no picture with the facts we have now. Even though there are good people in the field, there is insufficient money, insufficient data, insufficient services, insufficient everything except goodwill on the part of the Fondation and others.

"We thought it was time to go public," Mr Perras said.

"And, it seems to be the right moment. People are going to give because they are sensitized to the problem and also because they like Jean Lapointe, and they trust him."

COMMENT

GILBERT

Betel-nut chewing in Toronto

Last month, I described the world use of betel nuts, whose active ingredient, arecoline, is the fourth most popular psychoactive drug. Here are some guesses as to how many regular users of each of the four most popular drugs there are among the world's 4.5 billion people:

caffeine	3.5 billion
alcohol	2.5 billion
nicotine	1.5 billion
arecoline	1.0 billion.

I suggest that no other psychoactive drug has attracted more than 50 million regular users.

Arecoline — a drug having some superficial similarities in chemical structure and pharmacological effect to nicotine — is used mostly in India, Southeast Asia, Malaysia, and Polynesia. It is also used where natives of these areas have emigrated. In Metropolitan Toronto, home of more than 80,000 such immigrants, at least one million doses of arecoline are taken each year as betel-nut chews.

Betel nuts are sold in Toronto by the $1.79 bag of 20 at the many grocery stores specializing in foods from India. Prepared betel-nut chews — known in Hindi as *paan* — are sold at 50 cents each from 20 or so paan shops. I visited the Kamal Chaat paan shop in the heart of the East Indian district on Gerrard Street here to discuss paan preparation and chewing with Bhim Samnotra and Sanjai Kalra.

No place to sit

Kamal Chaat is a small place, no more than four metres by seven metres, including the open kitchen. To the left of the street entrance is the paan counter, on top of which are arrayed the 20 or so ingredients used in paan-making. At the rear are the kitchen and food counter from which is sold a small range of Indian delicacies. Between the two is an open space for chewing, eating, and talking. It is dominated by colorful advertisements for Indian films and two coin-operated video machines. A line of chest-high shelving around the wall serves as a food table. There is no place to sit.

Paan-making is an art involving the skillful blending of many ingredients to the user's taste. There are three kinds of paan. Preparation begins in each case with the pasting of a betel leaf with a dash of "soda" (actually slaked lime — calcium hydroxide) and a more generous amount of *kattha*, which is a lightish brown paste of mineral origin — so far unidentified.

Kattha is slightly alkaline. Thus, with the lime, it enhances the chewer's ability to extract alkaloids, particularly arecoline, from the paan, as described in last month's column.

Preparation rituals

Sweet paan is made by adding to the base a few pieces of betel nut (soaked in spiced marinade or unsoaked), and much in the way of spices and herbs, including rose petal solution, coconut, "aromas," honey with pink food coloring, and fennel and cardamon seeds. Burnt cloves may be added too, their flaming being part of the ritual of preparation.

. . . not as discouraging as my first cigarette . . .

Sour paan comprises more betel-nut pieces, but little in the way of herbs.

Sour paan with tobacco is prepared for the committed user. Spiced, powdered tobacco is added, in varying degrees of refinement according to the preference of the user. Various grades are available, ranging from #135 (coarse) to #460 (fine). The tobacco is sold separately at $10 per 50-gram can.

All ingredients are imported from India. Only the betel leaves present a storage problem. They are flown in twice weekly and carefully stored under water. The leaves are light green, oval in shape, and measure about 10 centimetres by eight centimetres.

The ingredients are piled in the centre of the leaf, which is then folded into an envelope around them. The prepared paan is slid into a foil sac for consumption off the premises, or put directly between gum and cheek for immediate use. Sweet paan are bulky. The novice user wonders whether there is enough space in the mouth.

A paan shop owner knows how each regular customer likes his paan made, much as a British pub owner will draw a regular's favorite brew as she enters the bar. Having one's order known without uttering it is, in both cases, a sign of recognition in the community. This paan shop is unusual in allowing customers, if they wish, to prepare their own paan — one reason for its popularity.

Customers come from many places in southern Ontario and even northwest New York state. United States immigrants of East Indian origin visit Niagara Falls for the spectacle and make the 150 kilometre side trip to Toronto for fresh paan. (Betel leaves cannot be imported into the US, but in Canada there are no restrictions on the importation and use of paan ingredients.)

Users include people of other origins, sometime resident in a betel-chewing area, and a few who have never left North America but are seeking a new and inexpensive pharmacological experience. I have heard that betel-chewing was a fad among young people in Montreal in the 1960s. The fad did not rate a mention in the exhaustive report of the Le Dain Commission of Inquiry into the Non-Medical Use of Drugs, published in 1973.

This paan shop does a fair business in preparing paan for weddings and other festivities. An order for 200 paan is not uncommon. In parts of India, you can insult a visitor to your home by not offering a paan soon after arrival. The custom lingers in the homes of immigrants in Toronto, supported by fresh paan purchased from the paan shops.

Women are not unwelcome at Kamal Chaat, but they usually chew at home rather than in public.

The paan shop performs much the same social function as the pub. It is a place to relax and meet friends, a centre of neighborhood gossip, and a political forum. Mr Samnotra was once a social worker with the Indian Immigrant Aid Society in Toronto. He says he is a more effective counsellor across the paan counter than he ever was across the desk of the society's office. Recent immigrants relax with him in the paan shop and unburden their problems and fears.

Brisk, sweet taste

I tried a sweet paan and liked the brisk, sweet taste. I was tired that evening, and the chew alerted me. I experienced none of the adverse effects on the novice described in my last column, perhaps because of the small quantity of nut in an otherwise large paan.

Two features of the chew were unpleasant. It soon became gritty: why, I was not sure. It could have been the nut pieces or the seeds, or both. I was tempted to spit the mess out, but continued for most of an hour in the interests of science. The other unpleasantness lasted two days. My dental fillings, particularly in my upper jaw, began to ache mildly, seeming more the result of a chemical than a physical assault.

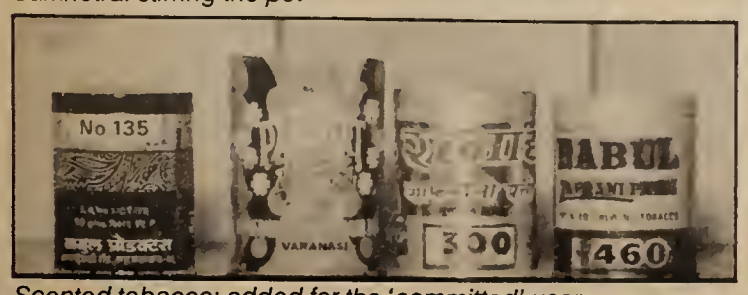
Neither unpleasant feature would deter me from chewing paan again, but the experience was not on balance pleasant enough for me to want to seek it out. If, as I believe, there are a billion regular users of betel nuts in the world, there must be more to the experience than I was able to encounter. It was certainly not as discouraging as my first cigarette, which I remember vividly across 34 years.

By Richard Gilbert

Samnotra: stirring the pot

Final touches: dash of chutney tops off sweet paan

Finished paan: insert between gum and cheek



Scented tobacco: added for the 'committed' user

Paan chewing: Gilbert samples paan with Kalra (left) and Samnotra

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Remembering 'The children remembered'. . .

Readers continue to respond to The Journal*'s special sections: The children remembered (April, May, 1985) and Families and alcohol (October, 1984).*

■ ■ Counsellor aid

I received a copy of The Journal in a package of information I requested from the Addiction Research Foundation some months ago. It has taken me this long to sit down and read your publication, but I must admit to being impressed with it when I did.

I am enclosing a subscription order and wonder if you could possibly obtain further information on two letters I read in the June, 1985 issue.

The first letter was a response to the April and May, 1985 articles. As the child of a former alcoholic, currently working in our local high schools as an alcoholism and the family counsellor, I would be interested in obtaining copies of the articles.

Secondly, one of the letters asked for more information on the program Values, Influences and Peers. Would it be possible for me to receive a copy of the kit or more information about it? As coordinator of a community-based "self-help" abuse prevention committee, I am always on the lookout for new programs and materials.

Thank you. I shall be looking forward to hearing from you.

Marnie Cuthill
Nakusp, British Columbia

■ ■ For discussion

I had the opportunity to read The Journal article The children remembered, Part II.

I would like, if possible, to obtain a copy of both sections.

I found Part II to be very informative and I would like to use some of the material for discussion in my adult children of alcoholics group.

Louis Praus
Dickinson, North Dakota

■ ■ Adult caseload

Please send me information about The Journal. I have read the special sections, Families and alcohol: a legacy of love and pain and The children remembered.

I am a therapist in private practice with a specialty in alcohol and other drug abuse. The majority of my clients are recovering alcoholics/addicts and most of those clients are adult children of alcoholic parents. In addition, there are many adult children of alcoholics in the remainder of my caseload. The information in your special sections has been very informative and helpful with these clients.

I would like information about subscriptions. Also, please send me bibliographies for the articles as well as the mailing address for the United States National Association for Children of Alcoholics.

Lilo Dixon
Novato, California

■ ■ Accurate stats

In your May, 1985 issue, Linda Sanford discusses sexual abuse and alcoholism (The children remembered).

I have never agreed with anyone more about anything in my career in this business of treating alcoholism, other drug abuse, and sex offenders.

In 1980, and again in 1982, I delivered lectures at the University of Minnesota Medical School's program in human sexuality, department of family practice, on the aspects of the combined treatment of alcoholism and sex offenders. Linda Sanford could have written the script. I can attest both to her statistics (mine are even more severe), and her philosophical approach to treatment.

I came to work at this institution in 1972 as an alcoholism counsellor after receiving treatment for alcoholism. As a trial attorney, I had the opportunity to work on cases of sexual molestation, rape, and other sex crimes. In 1977, I began to treat sex offenders after spending several summer and fall sessions receiving training. Our sex offender treatment program is very successful, with four women and four men counsellors who work with both types of people.

If Linda Sanford is looking for work, refer her to us. She certainly sounds like someone who knows and understands the need for multi-disciplined treatment.

Thanks for the article.

Jack D. Paul
Director of Programs
North Dakota State Penitentiary
Bismarck, North Dakota

Anecdotal use queried for NZ cannabis survey

The May, 1985 edition of The Journal contains an article, Marijuana favored by most young New Zealand doctors. The article focuses on a survey I conducted at a small meeting of house-surgeons and registrars earlier in the year, for the purpose of providing information for the meeting's discussion.

This group was not a random sample of New Zealand house-surgeons and registrars, and, therefore, no credible extrapolations from the results are possible.

John Aiken, MD, appears to have appointed himself spokesperson to the media for the group and has taken the liberty to add his own impressions in the process.

I have enjoyed being a regular reader of The Journal for some time. But, I am now beginning to doubt its purported commitment to research in the complex field of substance dependency. Advancement in knowledge is not helped by the anecdotal, sensational hearsay of fly-by-night thinkers and writers.

Doug Sellman
Registrar in Psychological Medicine
Alcohol and Drug Centre,
Canterbury Hospital Board
Christchurch, New Zealand

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of the sender may be sent to: The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

Kids on the run

'Drugs just make it easier'

TORONTO — Neglect of homeless youth is an "international scandal" requiring immediate action, a symposium on street youth was told here.

The symposium, The Street is No Place for a Kid, was told runaway youth living on the streets of North American cities number in the hundreds of thousands — an estimated 10,000 to 12,000 under 21 years of age roam Toronto streets alone.

Most come from families "wrenched by divorce or substance abuse."

A study of Toronto street youth (see pages K2-K3) provides further evidence that most, too, are victims of physical, sexual, and emotional abuse. Although they are victims, they are invariably treated as delinquents.

In a resolution, the symposium said homeless youth, unaware of how to use existing social services, "are forced to seek survival and nurturing in the exploitive and dehumanizing world of prostitution, crime, drugs, and pornography."

The resolution demands "that this international scandal be addressed, that government, private industry, and all sectors of our nations give the highest priority to meeting the needs of youth and their families . . . ."

The professionals also pledged "to educate youth as to their rights and options, to help them obtain the skills necessary to survival and self-respect, to tell the whole truth to the public about their plight, to cooperate with each other in providing the services they desperately need, and to regard them, above all else, as human beings in need of loving human relationships."

In this special section, Contributing Editor Joan Hollobon reports on the myriad problems facing street youth in North America. Photojournalist Daniel Gautreau, who has spent three years following the lives of street kids here and in Vancouver, provides photostories of some typical street youth.

Kids on the run — 'drugs just make it easier'

In the end you come out tough

'I don't worry about her going into drugs, she's seen eno that I'm not worried about her becoming a junkie, and, if has any hassles, she has lots of good friends that would do all kinds of favors — so, she's pretty well looked after.'

A mother discussing her prostitute-daughter's life on the streets

'I usually do a gram (cocaine) a day, but if I have more. I'l it. Like last Sunday, I went through six grams.'

An 18-year-old, male prostitute

'After seven years of fighting, my step-father kicked me o started staying with friends, and they were all into speed r ly heavy. I was a kid and I didn't know what to do, and ev body said: 'Here, do this, it's a good high, you'll like it.' I t it and I liked it and I did it again and again, and the guy kept giving it to me. One day, he said, 'You owe me for all speed.' So what am I supposed to do? He put me out on streets right away.

A young mother and 'sometime' prostitute

The money is good, but I'm feeling bad

If a trick or pimp don't get you, the booze and drugs probably will

Physical, verbal, and se

TORONTO — A study of 149 runaway teenagers living at Covenant House/Under 21 in Toronto reveals an alarming incidence of physical, sexual, and verbal abuse in the homes they left.

In the research project by a Massachusetts team, 40% said they had been attacked or raped, and 73% reported physical beatings, with 43% ranking physical abuse as a reason for running away from home. Fifty-one per cent said verbal abuse was an important reason for running.

The reason most frequently reported for running away — 54% — was "an unhappy life."

The youth — 63% male, 37% female — were between 15 and 20 years old.

They reported first leaving home at from four to 19 years of age; nearly one-quarter of them first ran away as preteens.

Younger runaways reported more abuse than older kids did; of the 34 preteen runaways, 85% reported physical abuse, compared with 69% for those who left in early adolescence and 70% for those who left as older adolescents.

Preteen girls

Sexual abuse was reported by 59% of the preteen runners, compared with 55% of the early adolescents and 44% of the older adolescents.

Both male and female preteen runaways reported more physical abuse than older children. But in cases of sexual abuse, the relationship with the age of leaving home was greater for girls than boys.

Preteen girls and girls who first leave home between 13 and 15 years were much more likely to report sexual abuse than females who first leave home as older adolescents.

Among the youth surveyed, 51% reported they had been offered money for sex by adults since leaving home; 36% had had sexual intercourse against their will; 31% reported having been sexually molested, and, 19% said they had been forced to observe photographs or films of the sexual act against their will.

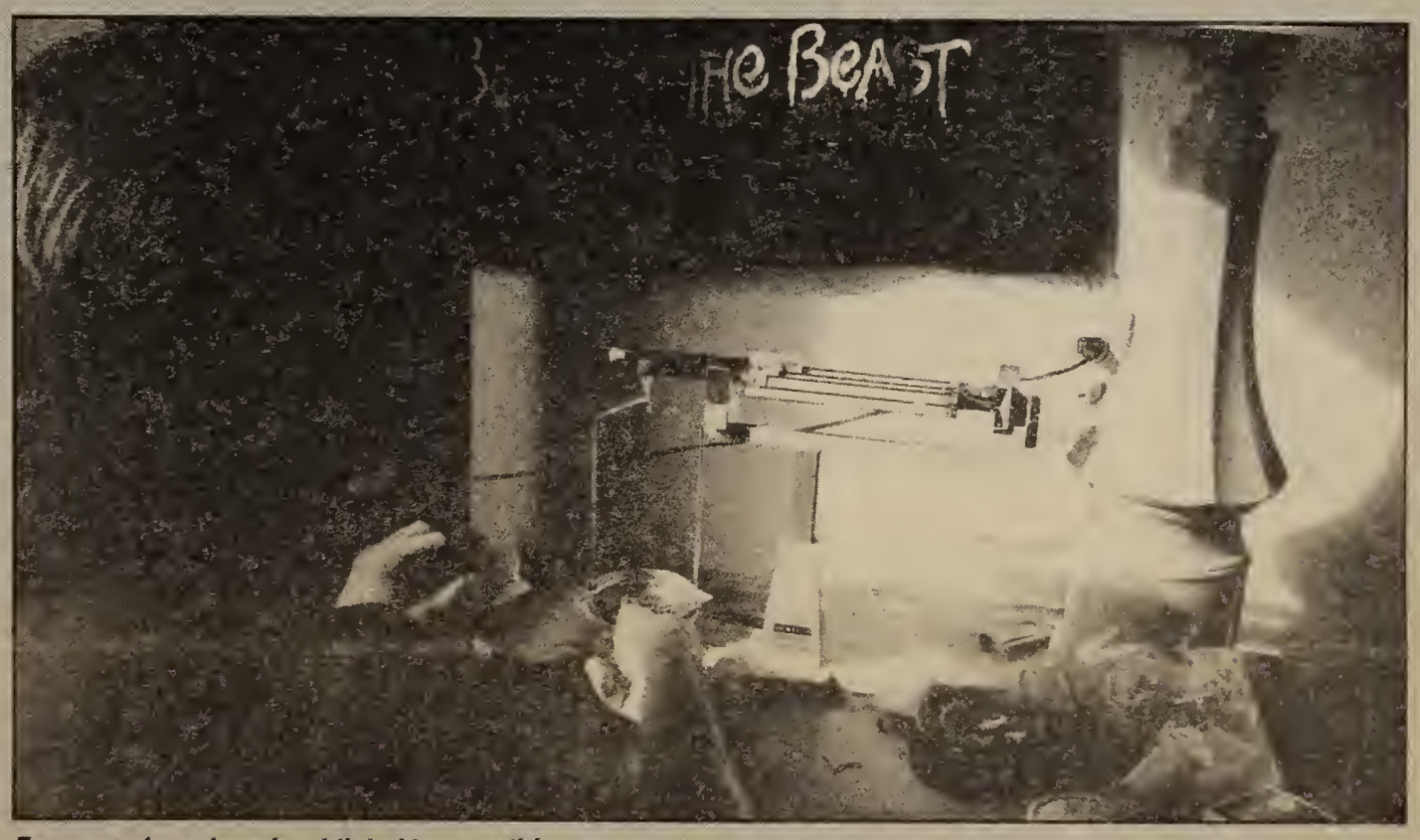
The survey was carried out in 1984 by Ann Burgess, van Ameringen Professor of Psychiatric Mental Health Nursing at the University of Pennsylvania and associate director of nursing research in the department of health and hospitals, Boston, Massachusetts; Arlene McCormack, PhD, assistant professor of sociology at the University of Lowell, Massachusetts; Judy Wood, director of the therapeutic arts program, department of psychiatry, Children's Hospital, Boston; and, Father Mark David Janus, a Paulist priest who has served as a research consultant to the United States department of health and human services on the use of children in pornography and as consultant to the sexual abuse team at Children's Hospital, Boston.

Dr Burgess said the sample was biased in favor of the more adjusted, functional youths who could return for a scheduled appointment, sit, read English, and understand the questions. Among reasons for not participating were inability to speak English, failure to keep an appointment, sus-

Where will I be in two years? Probably dead

Sometimes there's nowhere to run

All the drugs you do make you look old



Everyone down here is addicted to something

ual abuse plague street kids' early childhoods

ousness, agitation, and drug intoxica-

nong other major findings were the proportion of those reporting sexual e who came from single-parent homes om "reconstituted" families, homes one parent and a stepfather or step-ner.

Intact families

erall, the family composition of the hs was: 46% from intact families, 31% single-parent families, and 23% from nstituted families. But, in cases where al abuse was alleged, nearly double number came from single-parent or nstituted families as came from intact lies.

ore than 55% reported physical abuse me, regardless of family structure.

th physical and sexual abuse were likely to be reported from financially able homes. However, of the 110 run-vs who estimated their family income, reported incomes "higher than those nost people," 20% reported incomes r than most, and 39% reported in-es "about the same" as others.

e percentage reporting higher-than-age incomes was consistent with the ngs that 45% of families are supported ne incomes of both parents, Dr Bur-added.

most all the runaways — 94% — re-d a serious argument with one or both nts, and 88% reported serious argu-ts in the family. Nearly one-third — — reported someone in the family had had to go to court or had been arrested for a serious offence.

Trouble with school officials or employers was reported by 77%.

Alcohol and other drugs played a role in violence in the home.

Dr McCormack told **The Journal** a preliminary analysis — all aspects of the study have not yet been published — shows the existence of drug problems in 32% of the families where physical abuse occurred, compared with 19% of the non-abusing families.

Analagous figures for alcohol abuse were 33% against 24%.

Alcohol and other drugs were linked in questions designed to discover if sexually abused youth used substances more than young people not sexually abused. They were simply asked if they were in the habit of "getting high or drunk."

Overall, there was no difference: 53% of the sexually abused and 57% of the non-abused said they regularly got high on alcohol or other drugs.

There was, however, a marked difference between the sexes.

Males, abused and non-abused, reported about the same amount of alcohol or other drug use, but 55% of sexually abused females said they regularly got high or drunk, compared with only 20% of the non-sexually abused girls.

About 73% of the girls reported sexual abuse, compared with about 38% of the boys.

Dr Burgess said some of the runaways reported on their reproductive history: 23% of the males said they had fathered a child and 30% of the females reported having been pregnant.

Linking childhood sexual abuse to subsequent problems is not a new idea, but this study provides further evidence strategies used by victimizers to control their child victims induce responses in the children that are precursors to maladaptive behavior patterns, Dr Burgess said.

The sexually abused child is forced to make psychological, social, and cognitive adjustments in order to survive.

Dr Burgess said critical perspectives on social institutions — whether families, schools, or foster homes — are often best obtained from exiles, those who have left, which is why exiles are so often silenced or disparaged as deviant.

Labelling runaways as bad, delinquent, helpless, or losers successfully deflects attention from the institutions from which the youth flee, she said.

Dr McCormack said studies show runaway families are characterized by violence and abusiveness and are less likely than "normal" (nurturing) families to have members who are encouraged to act openly or to express feelings supportive of one another. Runaways perceive their families as displaying a high degree of openly expressed anger, aggression, and conflict.

Runaways' family members are less likely to be self-sufficient or to make their own decisions. More likely, they are pushed hard to compete in school or work. Control in the home is exercised by demanding conformity to inflexible rules, while discouraging independence.

Physically abused runaways have lower self-esteem than other runaways, and describe unhappy lives surrounded by financial troubles, verbal abuse, and alcohol and other drug misuse.

"Indeed, only 50% of those physically abused in the family report their families have been happy for more than three days," Dr McCormack said.

Vulnerability

Poor self-concept and inability to cope increase the vulnerability of young people trying to survive on the streets. Unfortunately, she said, the general public looks upon runaways as delinquent rather than vulnerable.

Dr McCormack says the study reveals that serious family dysfunctions, and not communication problems, produce arrested psychosocial development in the youth and "precipitate runaway behavior that prematurely introduces deficient youth to adult responsibilities . . . ."

The families, as well as the young people, may need "substantial therapeutic attention" to resolve the runaway incident.

Dr Burgess says about one-third of the kids manage to break out of the runaway cycle, returning to school or family or working at least sporadically. But, a negative outcome is the commoner pattern.

"Once on the street, the outcome can be prostitution, criminal activity, drugs, or death by suicide, drug overdose, or being murdered."

Kids on the run — 'drugs just make it easier'

'What can I say? January came and went, and I didn't even write. Today is January 31st, and I'll try and write a summary of what happened this month. The beginning was normal. High every day on DA, heroin, Talwin, or whatever. For no apparent reason, my baby's violence is elevating. I got beatings I wasn't sure I'd live through. In my mind, I'd beg God to stop him, but out loud I just asked B____ to stop and tried to protect myself. He doesn't realize it, but he dishes out some deadly beatings. Around the middle of the month, I got so depressed I thought he no longer loved me and with Dalmane, 40 Fiorinals, and 20 Valiums, I OD'ed. I pulled through only by the grace of God.'

An excerpt from a prostitute's diary, Vancouver

'It's Sunday night in Toronto. While most 17 year olds are finishing up weekend homework, a girl sits alone in a rooming house — waiting. Her boyfriend will return soon with more cocaine, paid for with $300 she earned that day prostituting herself on Toronto streets.

'Earlier, ambulance attendants were called because her friends thought she'd overdosed. Now, a few hours later, she's in need again.

'I asked her where she thought she'd be in two years. 'Probably dead,' was her answer. And, that's exactly what has happened to some 10 street kids I've met since I started this project.'

Daniel Gautreau, a freelance Canadian photojournalist, discusses street kids he met in Toronto and Vancouver during the past three years.

Being stoned just seems to make it easier

Covenant House: off the street, for a while

TORONTO — This first annual Symposium on Street Youth in North America was sponsored by Covenant House, an international child care agency with programs in Canada, the United States, and Guatemala.

Covenant House began in the winter of 1968/69 in the lower east side of Manhattan, New York, when a Franciscan priest, Father Bruce Ritter, took homeless youth into his own apartment, renting other apartments as the numbers grew.

As thousands of street kids knocked on his door during the next three years, it became evident staffing and financial support from friends was no longer sufficient. And, Covenant House/Under 21 became an approved child care agency.

In February, 1982, an Under 21 program opened here under the auspices of the Archdiocese of Toronto. Now, it is supported by the ShareLife campaign, the Ontario government, Metropolitan Toronto, and Covenant House, New York.

The theological and philosophical basis remains the same: "The covenant relationship, the offering of a consistent, personal love that challenges and confronts, but is never conditional and is never withdrawn."

Or, as Father Ritter says: "Covenant means constancy, fidelity — not going away, being there when you're needed."

At the symposium, Father Ritter blamed the "increasing number of failed families . . . failed parents" for the rising numbers of street kids who "almost universally are the victims of inadequate parenting."

All runaways are not street kids. Only a fraction of the one million US and Canadian youngsters who run away every year become street kids, totally disconnected from family, schools, work, churches, healthy adult relationships — from the entire political and social process, Father Ritter said.

Most street kids are forced to turn to prostitution because they have no other means of support or places to live.

The traditional background of the US street kid is the single parent in lower socio-economic circumstances. But in Canada, more come from relatively intact upper- and middle-class backgrounds. Here in Toronto, only 7% come from families on public assistance, Father Ritter added.

Toronto's Covenant House, open around the clock, seven days a week, has two buildings: a residence and an intake centre. The residence has 15 single bedrooms for boys and the same for girls, on separate floors, plus a full kitchen that prepares four meals a day for residents.

Generally, the kids stay from one day to three weeks.

Overflow

The intake centre sees an average of 10 to 15 young people a day, 70% of them males. But some months, they take in as many as 300 kids. The centre also acts as a dormitory for males waiting for a room and provides general "overflow" space.

Michael Knight, Covenant House's director of public relations, said one night in February, 82 young men slept on mats on the floor at the centre.

The program, says a Covenant House brochure, is designed to provide "immediate, practical crisis intervention and safety from the hazards of street life; adult, supportive counselling 24 hours a day; and, food, clothing, and emergency short-term shelter."

Health care and legal, educational, and vocational counselling are also provided, as well as referral to other social agencies as required.

An invariable rule is "no drugs." A youth who arrives drunk or high on other drugs is not admitted.

Cocaine

Mr Knight: "If a kid arrives after he's been drinking, staff would probably say, 'Why don't you walk around the block for an hour and come back when you're straight, and we'll take you in.' But, we've got 40 kids sleeping upstairs — we can't take the risk. We will send them to the Addiction Research Foundation (ARF), or to a detox centre, in a cab if necessary."

Lynda Pecora, a nurse practitioner at Covenant House, said if the clients are on drugs, they are almost certainly paying for them by prostitution, and "we can't have them doing that while they are living here."

Most of the girls who are prostituting spend most of their money on drugs, particularly cocaine, Mr Knight said.

Health centre staff see many conditions resulting from drug use but do not directly treat drug abuse.

"Lots of kids won't admit they have a problem — they don't think drinking 12 beers a night or smoking a few joints is a problem," Mr Knight said.

Ms Pecora agreed: "They are still enjoying it when they come to us — they haven't hit the bottom of the barrel. It's still a party — good times — the rot tends to set in a little later."

There are some street kids, though, who are drying out or want to be watched.

Getting young clients into treatment for alcoholism or other drug abuse is difficult, partly because of the lack of enough immediately available facilities and partly because of the clients' characteristic, low-frustration threshold.

Mr Knight: "We had a kid in here . . . and we discussed it all with him. He said how hard it was, and he wanted to get off (drugs). He was trying. He was tempted to go and have a beer, but he knew what would happen, and so on. But, he disappeared before we could get him into treatment. Many of them want everything NOW — 'I want my cough drops now, my OHIP (Ontario Health Insurance Plan) now, my entry now, my job now . . . .' "

Many of the kids also use unusual things, inhaling Pam (an aerosol cooking spray) or anti-asthmatic drugs like Beclovent (beclomethasone dipropionate).

Resisting help

Social worker Sonia Panchyshyn says she estimates about 80% of the clients have alcohol or other drug problems. More are solely on drugs other than alcohol, but many are cross addicted.

"But, most are very resistant to doing anything about it. They say, 'I'm handling it on my own' or, after the tenth time in here, they'll say, 'Oh, this time I have it under control.' They haven't, of course," she said.

Ms Panchyshyn tries to make the kids see realistically how their drug habit interferes with other areas of their lives, including holding a job. But, "half the time," they fail to keep appointments she makes with, for example, the ARF.

Only two young people were willing to commit themselves to a six-month program. They successfully completed treatment at an Ottawa centre called Our House staffed largely by former addicts.

Cultural, economic shifts take their toll

Alcohol problems now reaching tropical Fiji

In recent years, social, economic, and cultural changes in Fiji have resulted in alcohol-related problems for the southwest Pacific nation. United States journalist ***Marie Wilson****, who lives on the islands, reports that officials recognize the need to encourage sensible drinking habits and to provide the country's 650,000 people with education and prevention information.*

SUVA, Fiji — This country of islands is beginning to take a close look at the effects of alcohol use on its population, as concern grows about the increase in related thefts, physical abuse of women and children, and traffic accidents.

Few studies have been done, and statistics are available on a limited basis only. But, it is known here that the problem is complex.

Alcohol use on the islands is relatively recent, and the public — as a whole — has little awareness of detrimental effects.

Compounding the problem is the socially accepted tradition of men gathering around the *yagona* bowl Yagona, a national drink, is made from the powdered root of the pepper plant *(Piper methsticum)*. Water is added, and the mixture is strained through a cloth. Though non-alcoholic, the drink is slightly narcotic and somewhat addictive.

The social acceptance of yagona carries through to alcohol.

Here, alcohol may be purchased by anyone 18 years old. Enforcement of the age limit is negligible.

Consumption of methylated spirits — an offence but a common one because the product is cheap and highly intoxicating — is another problem, especially among the young.

Fiji is attempting to educate its citizens about alcohol-related problems. Says T. M. Biumaiwai, permanent secretary for health and social welfare: "Prevention at all levels is of primary importance."

Because the people are religious, ministers and other church members are used to conduct seminars on alcohol awareness. There has been some success. Regular seminars by one organization have reached more than 12,000 people in the past two years. Reportedly, more than 1,400 people have quit drinking as a result.

Other programs include hospital involvement, introduction of new products, and government action.

Hospitals have been asked to keep records on the admittance ratio of alcohol-related accidents and illnesses to help officials gather statistics. Light beer with lower alcohol content is now available and sales have been brisk.

A government committee has been formed to look into the problem and make recommendations.

A legislative bill, expected to be passed later this year, is being introduced in parliament. The public, transportation officials, and government have offered support.

The bill states it is an offence to drive a motor vehicle with a blood alcohol level of more than 0.10%. Breath tests are expected to be used as a deterent to impaired driving.

Penalties will range from fines of up to $400 (Cdn $536) for the first offence plus loss of licence for three months to two years, to double that plus optional imprisonment of up to six months for a second offence, to a fine of up to $1,500 with mandatory licence loss for five years and mandatory imprisonment of three months to two years on a third conviction within five years.

Shifting values: brisk sales, traditional yagona bowls, and a government committee

Scottish study reappraises controlled drinking concept

By Alan Massam

LONDON — A Scottish psychologist says concepts like "one drink, one drunk" should be discarded following scientific observations that some problem drinkers can learn to control their drinking.

A new appraisal of the controversial idea was given to the annual meeting here of the British Association for the Advancement of Science.

Ian Robertson, honorary fellow, department of psychiatry, University of Edinburgh and principal clinical psychologist at the city's Astley Ainslie Hospital said the belief that alcoholism is a disease was put forward in the 18th and 19th centuries. The theory only began to achieve acceptance in the wake of the end of prohibition in the United States in the 1930s and 1940s and was consciously advanced to improve the image of alcoholics and to secure more funds to help them.

Mr Robertson said this view of alcoholism was acceptable to the public, politicians, and, most of all, to the beverage industry, as it blamed alcoholism on the individual and not on the drug, ethyl alcohol.

The fact the view still applies, he said, can be seen by the reaction of various industry lobbyists to the British Medical Association's proposal to curb alcohol problems by increasing price and banning advertising.

The principal argument of alcohol producers, Mr Robertson said, is that alcoholics crave alcohol because of their illness and would not be deterred by price increases.

"Recent research shows this is not the case. Price increases reduce the alcohol intake of the heaviest drinkers as much as the lightest. And, this fits in with a new model of alcohol problems called the social learning theory.

"Alcoholics — or problem drinkers as proponents of this theory would prefer to call them — do not drink principally for physical reasons, but rather as victims of habit like smoking, compulsive gambling, or heroin addiction.

"And, in the same way that smoking and heroin use are affected by price increases, so is drinking.

"Most assumptions about the disease model of alcoholism have had to be discarded or radically changed in the light of scientific research, including notions of irresistible craving, loss of control, and the 'one drink, one drunk' theory."

Mr Robertson adds that problem drinkers who learn to control their drinking tend to be younger people who are less dependent on alcohol but who are nevertheless running into problems.

"Insisting that people like this abstain when they want to try to cut down their drinking can actually be harmful."

Mr Robertson said the new approach to alcohol problems results in a range of programs for people with less severe alcohol problems — those who in the past might have been dismissed as 'not really alcoholics.'

Under the new approach, he said, there is no clear dividing line between heavy drinkers and alcoholics. Alcohol problems are seen as a continuum with light drinking at one end of the spectrum and heavy drinking at the other. Advice and help are offered to those in the middle of the spectrum rather than those at the ends.

Mr Robertson reported on a number of studies backing his hypothesis. He said if problem drinking is to be understood in terms of social learning theory, the individually focused disease perspective must be substituted by a view explaining alcohol problems as interactions between drinkers and their micro and macro environments.

NEWS

Britain rallies to aid Pakistan in war on opium

By Thomas Land

LONDON — Britain will contribute an extra £2.4 million (Cdn $5 million) to an internationally financed program aimed at eradicating opium poppy cultivation in Pakistan's North-West Frontier Province — the productive heartland of the notorious Golden Crescent of the Middle East.

The contribution follows a visit by Home Office Minister David Mellor to the remote opium-poppy growing region near the Afghan border. The area produces an estimated 80% of the heroin consumed in Britain. A coincidence of circumstances there has recently set off a productivity explosion, which is flooding the lucrative black markets of the Western world with cheap, high-quality heroin.

Several senior Western policemen have accused their Pakistani counterparts of widespread corruption that frustrates international efforts to control the illicit trade. Many countries — including Australia, Norway, Holland, West Germany, and the United States — have established or strengthened their own drug control agencies in Pakistan under diplomatic cover.

But, the new British financial backing amounts to a public expression of confidence in Pakistan's ability and willingness to play its part in the collective drug control project.

Britain is to finance the balance of funds needed for a program to eliminate poppy cultivation in the Dir district of the North-West Frontier Province which accounts for about half the total area producing opium in Pakistan.

The project is being organized by the United Nations Fund for Drug Abuse Control (UNFDAC) in support of Pakistan's policy to eradicate the opium industry. The overall aim of the international project is to create alternative farming

Peshawar bazaar: in the heart of opium country

systems and employment opportunities in the main opium-growing areas. This will allow the local people to comply with the government's ban on poppy cultivation.

Based on a rural development plan drawn up by British specialists, the project includes soil conservation, timber and firewood production, irrigation and safe drinking water schemes, improved agricultural research, advisory services, and welfare programs.

Says a specialist for Britain's Overseas Development Administration: "As a result of Pakistan's efforts at enforcing drug control laws and encouraging crop substitution, the amount of opium grown in the country has fallen to about 45 tons in 1984 from 800 tons in 1979. Britain hopes its new contribution will encourage other donors to support Pakistan's program to combat drug abuse."

Britain earlier pledged £1 million to the UNFDAC's Dir program while the US and Italy raised £3.3 million each. West Germany was first to invest in agricultural development in Pakistan specifically as a means of reducing opium production (**The Journal**, March, 1985).

The Golden Crescent is a vast opium-growing area comprising Pakistan, Afghanistan, and Iran. The world's other principal source of heroin is the Golden Triangle of Asia which includes sections of Thailand, Burma, and Laos; its productivity has recently declined for a variety of reasons, including several internationally financed crop substitution projects and a military clampdown by the Thai government.

Tobacco promos spur protest groups to counter-attack

By Alan Massam

LONDON — The tobacco industry here is facing increasing embarrassment from protest groups who use imagination and youthful enthusiasm to press home the harsh facts about smoking-related deaths and illnesses.

Two of these groups — TREES (Those Resisting an Early End from Smoking) and COUGHIN (Campaign On the Use of Graffiti for Health in the Neighbourhood) — seem inspired by health workers at the Royal Free Hospital in Hampstead, North London.

TREES specializes in unannounced appearances at sports and cultural events sponsored by tobacco companies, while COUGHIN defaces tobacco advertising — along the lines of the longer-established Australian group BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions) [**The Journal**, March, 1984].

Applause for TREES has come from the British Medical Association's *News Review*. Editor Tim Albert writes: "The cigarette companies are brilliant propagandists. Their subtle and glamorous images beam down at us from roadside hoardings and from the backs of countless magazines, many of which find their ways into doctors' waiting rooms.

"However, I am pleased to report signs of fightback. In London, a group of young doctors and other health workers, based mainly at the Royal Free Hospital in London, have founded TREES.

"In their first few months, they appeared at the Benson and Hedges cricket cup final at Lords giving out information leaflets and balloons (Happiness is Healthy Lungs) and sunvisors (Burnson and Stenches Stunts Your Growth).

"They picketed the John Player portrait competition awards and staged a Lung Slayer Special Dance of Death at the Royal Festival Hall before a tobacco-company-sponsored performance of *La Sylphide* (**The Journal**, January).

Mr Albert notes that TREES and COUGHIN share an address (PO Box 316, London E2 9PP) and reports that similar activities are occurring in Newcastle.

A recent issue of the TREES newsletter says the latest figures on smoking from the Office of Population Consensus and Surveys make "depressing" reading.

"The decline in the percentage of women and men who smoke is painfully slow and working-class people continue to be the major consumers of tobacco and thus those who will suffer smoking-related diseases most heavily.

"We think the tobacco industry must be attacked directly if this situation is to change; most importantly, all advertising and promotion of tobacco through sponsorship, exhibitions, and so on, must be banned."

Dr Kettil Bruun, Finland

HELSINKI — Kettil Bruun, PhD, director of the Finnish Foundation for Alcohol Studies for 25 years, died here in December.

Winner of the 1971 Jellinek Memorial Award, Dr Bruun was co-author of *The Gentlemen's Club*, a 1975 critical appraisal of international drug and alcohol control. He was also well known for another work, *Alcohol Control Policies in Public Health Perspective*.

Dr Bruun was active internationally as a member of the World Health Organization expert advisory panel on drug dependence and alcohol problems and as chairman of the Nordic Council for Alcohol and Drug Research.

HOWELL

What's hot, what's not

How many times has it happened to you already? You're sitting around having coffee with your colleagues and suddenly someone mentions psychoesthetics. And, you feel like a dummy — like the first time you heard the term 'Yuppie,' and someone had to explain to you what it meant.

How many times have you said: 'I'd like to be *au courant* with this new academic discipline of psychoesthetics I hear so much about, but I don't know where to begin?' Well, folks, you can begin here, with this annotated bibliography of psychoesthetic theory:

The New Pap-acy — J. A. Vitgenstein.

This seminal volume is considered the *Silent Spring* of psychoesthetic thought. For just as Rachel Carson's book caused the world to sit up and take notice of the dangers of chemical pollutants in the atmosphere, Mr Vitgenstein's book was the first to point out entertainment as we know it was undergoing a sea-change and metamorphosizing into something strange, but not necessarily rich.

Way back in 1983, the prescient Mr Vitgenstein saw feature movies were beginning to look more and more like television shows, TV shows were beginning to look more and more like rock videos, rock videos were beginning to look more and more like TV commercials, and — horror of horrors — TV commercials were beginning to look more and more like rock videos, and so on and so forth. Mr Vitgenstein predicted if these trends continued, a perfect homogenicity would be achieved by the year 1990.

The American Journal of Psychoesthetics — J. A. Arinbuck, founder and editor.

This is essential reading, especially up to and including the June, 1984 issue — the one that resulted in what psychoesthetic ians refer to as "the great schism." Mr Arinbuck's dogmatic insistence that the rot had set in with the introduction of jump-cut, hammer-rhythmed beer and soft-drink commercials, and his refusal to accept papers suggesting such TV commercials arose out of the influence of rock videos, ultimately resulted in the formation of a psychoesthetic splinter group.

The New American Journal of Psychoesthetics — Sheila J. Dungaree, founder and editor.

Although the papers in the *New Journal* tend to lack the intellectual and academic rigor of those published under the redoutable Mr Arinbuck's imprimatur, the *New Journal* is, nevertheless, indispensable reading for a newcomer to the-psychoesthetic scene.

For instance, it was in the September, 1984 issue the French scholar T. De Chardonnay made his bold prediction that, within two years, enterprising producers would find ways to stretch the beer-commercial/rock-video formula to encompass not only a 60-minute slot on prime time, but also a 90-minute feature-length film. Psychoestheticians laughed at the time, but *Miami Vice* and *Flashdance* appeared on schedule, making big bucks for their producers and a big reputation for T. De Chardonnay.

False Prophets of the New Age — J. B. Comstock II

You can give this book a miss. Although he has some interesting and original points to make, Mr Comstock's obsession with Satanic messages places him outside the mainstream of psychoesthetic thought. Indeed, most of the book deals with technical matters, such as how to get your video cassette recorder to play backwards so you can monitor the alleged messages.

Serious psychoestheticians consider Mr Comstock a kook. As Sheila J. Dungaree so delightfully put it, in one of those biting editorials that are her trademark, "We've got Coors beer ads, Madonna videos, *Miami Vice*, and John Landis movies; we've got our hands full with The Devil we know, who cares about The Devil we don't."

APPPN

The Associated Professional Psychoesthetics Professional Newsletter allows one to keep up on the latest in psychoesthetic research. For instance, the February, 1986 issue contains the following articles:

Identification Obfuscation — by Wilhelm H. Reit. Mr Reit, a former protegé of Mr Vitgenstein, subjected 10 average teenagers (five from Peoria, five from Winnipeg) to 90-second spots from a typical made-for-TV movie. Four thought they were watching a Pepsi commercial; three thought they were watching *Footloose II*; two thought they were watching a beer ad; and, one said he didn't know what it was, but it was okay with him. (When Mr Reit reported these findings to the director, the director was ecstatic and predicted his pilot would become a series.) For comparison purposes, Mr Reit also subjected the 10 typical teenagers to 20 minutes of *Casablanca*. At least, he tried to; they could not tolerate it. As they put it, "Too much talk . . . the Swedish babe never danced . . . and, we got tired of waiting for Rick to blow those Nazi suckers away."

Sesame Seeds of Destruction — T. De Chardonnay. This ambitious paper attempts to relate the current "reductionism" in entertainment to policies of The Children's Television Workshop, policies based on the assumption that the natural human attention span is less than 60 seconds. Mr De Chardonnay argues that *Sesame Street* has created a "monster generation" of short-spanners, which is now being catered to by TV ad executives who have cut the average ad-span to 30 seconds from 60, and TV producers who demand that TV drama scripts deliver a "jolt" within the first minute — rape, a murder, a car pile-up, or whatever. The hypothesis does not appear to be supported by the statistics, but that caveat notwithstanding, one cannot safely ignore Mr De Chardonnay, remembering how he predicted, as early as 1984, that a TV show would appear that would be a veritable apotheosis, a sublime synthesis, of sex, drugs, rock-and-roll, and Rambo-style violence. And, less than two years later, *Miami Vice* appeared in all its glory.

By Wayne Howell

DEPARTMENT

New Books

by MARGY CHAN

Behavioral Teratology: A Bibliography to the Study of Birth Defects of the Mind

. . . compiled by Ernest L. Abel

This bibliography contains references to materials published prior to 1985 and dealing with the effects of prenatal exposure to drugs, environmental pollutants, X-rays, etc, on behavior after birth. Entries are arranged by type of agent, including amphetamines, antidepressants, barbiturates, benzodiazepines, caffeine, LSD, marijuana, narcotics, neuroleptics, and tobacco.

This comprehensive compilation will be of interest to medical and behavioral researchers, physicians, and social workers.

Greenwood Press, 88 Post Road West, Box 5007, Westport, Connecticut 06881. 1985. 206 p. $35. ISBN 0-313-25066-9.

The Marijuana Question and Science's Search for an Answer

. . . by Helen C. Jones and Paul W. Lovinger

This book provides a comprehensive account of the more significant scientific research on marijuana and the experience of smoking. It is organized into three main parts: cannabis and the different vital systems of the body; cannabis and the psyche; and, cannabis and various aspects of society, such as driving, crime, aviation, and the military. In addition to factual studies, the book includes comments from interviews conducted with many marijuana users and ex-users.

The authors have succeeded in writing a very readable book on a complex subject for general readers and, at the same time, providing well-documented research information for the serious student or professional. The book contains extensive source notes with full bibliographical references.

Dodd, Mead & Co, 79 Madison Avenue, New York, NY 10016. 1985. 537 p. ISBN 0-396-08398-4.

Behavioral Analysis of Drug Dependence

. . . edited by Steven R. Goldberg and Ian P. Stolerman

This book gathers together the main findings of years of research on the behavioral aspects of drug dependence. It is written by scientists with distinguished research records in their respective fields, and each chapter deals with a specific aspect of the experimental analysis of drug-taking behavior. Instead of focusing on the pharmacology of specific classes of drugs, the book deals with behavioral processes, such as drugs as reinforcers, discrimination of drug effects, and classical conditioning. The book will be useful for research workers and treatment professionals of drug dependence.

Academic Press Canada, 55 Barber Greene Road, Don Mills, Ontario M3C SA1. 414 p. ISBN 0-12-287141-3.

Other books

The Substance Abuse Problem: Vol 2 — New Issues for the 1980s — Sidney Cohen, (ed), 1985. The two volumes will serve as a definitive reference for professionals in the field. Issues covered include: cocaine, marijuana, alcohol, other mind-altering substances, and an assortment of related problems. Index. Haworth Press, New York. 323p. $34.95. ISBN 0-86656-368-7.

Alcohol: Preventing the Harm — Institute of Alcohol Studies, London, 1985. Papers presented at the conference held in London, November, 1984. The determinants of per capita consumption; the social cost of alcohol use; community approaches to the problem of alcohol misuse; what can better health education policies achieve?; the politics of alcohol control — obstacles to prevention. The Institute of Alcohol Studies, Alliance House, 12 Coston St, London, SW1H 0QS. 90p.

Alcohol and the Developing Brain: Third International Berzelius Symposium sponsored by the Swedish Society of Medicine — Ulf Rydberg, *et al* (eds), 1985. This book contains contributions by many of the world's experts. It discusses the problem of alcoholism at the molecular, neurobiological, clinical, and social levels. Educational programs for prevention of alcohol abuse are also reviewed. Index. Raven Press, New York. 221p. $55. ISBN 0-88167-127-4.

Roads to Recovery: A National Directory of Alcohol and Drug Addiction Treatment Centers — Jean Moore (ed), 1985. A national, state-by-state guide to alcohol and other drug addiction treatment centres in the United States. Each entry includes a brief description of the therapeutic approach, accommodations, specific programs, number of patients, admission policies, minimum length of stay, costs, and insurance eligibility. Collier Books/Macmillan, New York. 384p. $17.95 paper. ISBN 0-02-059470-4.

Excessive Appetites: A Psychological View of Addictions — Jim Orford, 1985. Five forms of excessive behavior are described in the first part of this book: drinking, gambling, drug-taking, eating, and sex. Part two is devoted to the development of a psychological model of excessive appetites. Contains an extensive bibliography. Index. John Wiley & Sons, Toronto. 367 p. ISBN 0471 103012.

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

My Last Chance in Life

Number: 729.
Subject heading: Drug use, etiology and epidemiology, sports.
Details: 12 min.
Synopsis: Maury Wills was one of the best baseball players in the United States. His goal, to manage a major league team, was achieved when he became manager in Seattle. The team did poorly, and he was fired in his first year. He became a cocaine addict, lost everything, and nearly died. Don Newcombe, a former Dodger player and employee assistance worker, started Mr Wills on the road to recovery. Mr Wills now travels across the US telling people what happened to him in an effort to help others.
General evaluation: Good (4.2). Mr Wills comes across realistically. This film could lead to good discussion on the problems cocaine can cause.
Recommended use: The film could benefit those 12 years and older, especially those involved in sports.

The Journal
Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)
Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases
Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254
Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $18 per year
Air Mail: add $19 per year
Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.
The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

All Our Business

Number: 728.
Subject heading: Alcohol and the family — Native people.
Details: 28 min.
Synopsis: Mary and Bill, a young Native couple, hear what they think is a violent family argument in a neighbor's house. At her mother's suggestion, Mary visits the woman and sees evidence that Jean has been beaten. However, Jean refuses to talk. Mary seeks information from neighbors, a policewoman friend, and the referral centre. She learns that Jean's husband drinks a great deal and becomes violent. Mary returns to Jean and offers to shelter her if her husband becomes violent again. Jean takes Mary up on her offer and stays with her and Bill until Jean's husband gets help for his problem.
General evaluation: Fair to good (3.8). This film is a realistic portrayal of family violence and could lead to discussion about possible solutions.
Recommended use: With a resource person, this film could benefit Native families discussing family violence.

This publication is indexed in
BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

Alcohol and the Family: The Breaking Point

Number: 727.
Subject heading: Alcohol and the family.
Details: 29 min.
Synopsis: Jim is an alcoholic, yet his wife, Sally, denies it and the family situation deteriorates. Patsy is also an alcoholic; her husband continues to deny the problem. We see the effects of parental drinking on the children — broken promises, extreme mood swings, and arguments. Each family tries to deal with the problems created in its own way, but the situations still worsen. Eventually, each spouse seeks help and confronts the drinking partner.
General evaluation: Good (4.4). This well-produced film realistically portrays problems many families face when one member is an alcoholic. This film could lead to good discussion about coping within the family and treatment facilities. Public broadcast is recommended.
Recommended use: With a resource person, this film could benefit those 12 years and older, especially members of families in which alcohol is a problem.

Smokeless Tobacco: It Can Snuff You Out

Number: 730.
Subject heading: Tobacco.
Details: 20 min.
Synopsis: The hazards of inhaling cigarette smoke are well known. Recently, tobacco companies have been promoting smokeless tobacco — tobacco put into one's mouth and held there. Both health and social consequences arise. Some health professionals have predicted an epidemic of oral cancer. Young people tell of their experiences with smokeless tobacco, including their difficulties in quitting. One young man's death illustrates the potential hazards of smokeless tobacco.
General evaluation: Very good (5.0). Although this film may have been strong in its statements, it was judged a good teaching aid that could lead to attitudes against drug abuse. General broadcast is recommended.
Recommended use: With a resource person, this film could benefit especially those 12 to 18 years of age.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Can I Take This If I'm Pregnant? — April 14, Toronto, Ontario. Information: Cathy Blake, special events, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

What an Employer Needs to Know to Make an Effective Intervention — May 7-9, Toronto, Ontario. Information: Intervention services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Preventing Alcohol and Other Drug Abuse Within Our Society — May 15, Toronto, Ontario. Information: Ontario Council for Leadership in Educational Administration, 252 Bloor St W, Ste 12-115, Toronto, ON M5S 1V5.

Youth and Drugs, PRIDE CANADA Conference — May 22-24, Saskatoon, Saskatchewan. Information: Eloise E. Opheim, PRIDE CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Ontario Medical Association 106th Annual Meeting — June 9-12, Toronto, Ontario. Information: Annual meeting coordinator, OMA, 250 Bloor St E, Ste 600, Toronto, ON M4W 3P8.

77th Annual Conference of the Canadian Public Health Association — Health Promotion Strategies for Action — June 16-19, Vancouver, British Columbia. Information: CPHA, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

Summer School for Addiction Studies — July 7-25, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

27th Annual Institute on Addiction Studies — July 13-18, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

North American Congress on Employee Assistance Programs — Aug 5-8, Toronto, Ontario, Information: Diane Vella, 2154 Crooks Rd, Ste 103, Troy, Michigan 48084.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

United States

National Nurses Society on Addictions Annual Conference — April 11-13, Chicago, Illinois. Information: NNSA, 2506 Gross Point Rd, Evanston, IL 60201.

NCA Annual Conference — April 18-21, San Francisco, California. Information: National Council on Alcoholism, 12 W 21 St, New York, NY 10010.

American Medical Society on Alcoholism and Other Drug Dependencies and the Research Society on Alcoholism — Joint Meeting — April 18-22, San Francisco, California. Information: AMSAODD-RSA Meeting, 12 W 21st St, New York, NY 10010.

3rd National Conference on Alcohol and Drug Abuse Issues in Higher Education — April 27-29, San Antonio, Texas. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St NW, #181, Washington, DC 20001.

NECAD 86 — May 4-7, Newport, Rhode Island. Information: Jane Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Rd, Newport, RI 02840.

The National Association of Alcoholism Treatment Programs 8th Annual Meeting — May 6-9, Anaheim, California. Information: NAATP, 2082 Michelson Dr, Ste 304, Irvine, CA 92715.

American Psychiatric Association Annual Meeting — May 10-16, Washington, DC. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

MDMA (Methylenedioxymethamphetamine): A Multi-disciplinary Conference — May 17-18, Oakland, California. Information: Stephanie Ross, Haight-Ashbury training and education project, 409 Clayton St, Box ED, San Francisco, CA 94117.

5th National Conference on Chemical Dependency — May 21-24, Philadelphia, Pennsylvania. Information: Caron Institute, Box 227, Galen Hall Rd, Wernersville, PA 19565.

International Drug Development in the 21st Century — 22nd Annual Meeting, Drug Information Association — June 1-5, Washington, DC. Information: Drug Information Association, PO Box 113, Maple Glen, Pennsylvania 19002.

American Society of Hospital Pharmacists — June 1-5, Denver, Colorado. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

Sage Conference: Preventing Relapse in Addiction — June 9-11, Adrian, Michigan. Information: Miriam M. Stimson, director, graduate studies, Siena Heights College, 1247 E Siena Heights Dr, Adrian, MI 49221-1796.

48th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 16-18, Tahoe City, California. Information: Mary Jeanne Kreek, Committee on Problems of Drug Dependence, Inc, The Rockefeller University, 1230 York Ave, New York, NY 10021.

37th Annual Symposium on Alcoholism — June 16-27, Seattle, Washington. Information: Alcohol studies program, Seattle University, Seattle, WA 98122.

Abroad

15th International Institute on the Prevention and Treatment of Drug Dependence — April 6-11, Amsterdam/Noordwijkerhout, The Netherlands. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

2nd Annual International Industrial Alcoholism Symposium — May 20-22, Frankfurt, Germany. Information: Annette Stappert, conference coordinator, Conecta, 12 Stooter St, 4330 Mulheim 13, Germany.

32nd International Institute on the Prevention and Treatment of Alcoholism — June 1-6, Budapest, Hungary. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

International Symposium on Drinking and Driving: Role of the Alcoholic Beverage Industry — June 4-6, Amalfi, Italy. Information: International Center for Transportation Studies, Viale Bruno Buozzi, 53 00197 Rome, Italy.

3rd Congress of the International Society for Biomedical Research on Alcoholism — June 8-13, Helsinki, Finland. Information: Sari Salo, 3rd ISBRA Congress, Alko Ltd, PO Box 350, SF00101, Helsinki, Finland.

International Symposium on Health Education in Schools —July 6-10, Jerusalem, Israel. Information: D. Tamir, International Symposium, PO Box 394, Tel Aviv 61003 Israel.

14th International Cancer Congress — Aug 21-27, Budapest, Hungary. Information: Crimson Travel Service, 39 John F. Kennedy St, Cambridge, Massachusetts 02138.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

Vienna 81

Cynicism, idealism, and the future

International drug control policies, put into place to protect the global community, are essentially developed by bureaucrats meeting on neutral territory — the United Nations. For decades, Canadian experts have contributed significantly to this world effort. Now, however, as nations around the world prepare for a top-level meeting on drug trafficking and abuse next year in Vienna, Canada's commitment is in question. For almost a decade, Anne MacLennan, editor of ***The Journal****, has kept abreast of evolving UN policies and debates, among and between countries, reporting on the contribution of and the impact on Canada. Following is her analysis of some of the hurdles officials — here and in other countries — face, both at home and on the international stage, in the run-up to the 1987 meeting.*

Anne MacLennan reports

VIENNA — Fifteen months from now, in June, 1987, when this city is greened and flowered for another summer of Strauss in the parks, several hundred senior government ministers, deputies, and assorted other bureaucrats and experts will arrive with drugs on their minds.

Their meeting is expected to be the biggest on international drug abuse and illicit trafficking — in terms of numbers and impact — the world has ever seen or is likely to see again soon.

The pressure for this "drug summit" came to light publicly and officially in May, 1985, when a diplomat from Peru tripped a wire of concern that was cutting across South America — a continent that both houses and exports onerous drug problems.

Venezuela, particularly, was becoming aggressive about its vulnerability to its neighbors — the continent's three cocaine sore spots — Peru, Bolivia, and Colombia.

The wire was cutting across other areas as well — for different reasons. Malaysia, for instance, a relatively innocent bystander as world drug problems had increased, was now experiencing the impact of being an illicit drug-transit country — an alarming leap in domestic drug abuse problems.

In the United States — where drug users for decades have seemed able to swallow whatever the rest of the world can supply — it was the year of the "First Ladies" (**The Journal**, June, 1985).

The global nature

Spring had seen Nancy Reagan, wife of President Ronald Reagan, inviting spouses of other world leaders to Washington and to a meeting of concerned parents in Atlanta, Georgia, to study for themselves the effects of drug abuse on children and families and to understand the global nature of drug problems. (Mila Mulroney, wife of Canada's prime minister, carried a note describing the federal-provincial nature of the system in Canada and some current activities in the drug field.)

Then, last May, that Peruvian diplomat, Javier Perez de Cuellar, secretary-general of the United Nations, told the UN Economic and Social Council the world needed a drug conference.

This one, he stressed, must draw people from the highest levels of governments — the people with the power to change things — because drug abuse and trafficking were now threatening the stability of governments.

It was the first time a secretary-general had shown direct interest in drugs. It was also a call for high-level political commitment — suggesting there was already political pressure — for something more than technical assistance and support from the health and justice bureaucrats who have guided the development of international drug policy since it first became necessary some 70-odd years ago.

Within months, not surprisingly, the UN system had approved the idea; gathered the evidence that sufficient political support would be forthcoming; appointed a chief organizer; set a date, venue, and general theme and structure for a meeting; and, developed a proposed agenda for further refinement by the technical experts — the UN Commission on Narcotic Drugs.

Most people who attend the February Commission meetings here, as well as being bureaucrats, are social workers, pharmacists, lawyers, physicians, policy experts, customs officers, narcotics enforcement officers, chemists in their home countries.

More and less

At the meetings, they are both more and less than any of those things. More, because here they represent their governments or international agencies and, in a way, their professional peers. Less, because however influential are their voices at home, or in their own disciplines, here the din is louder.

They are also subject to, as well as objects of, cynicism. After 40 years of Commission meetings and treaties, it's too late to ask what might have happened if international efforts had never been made.

The stark fact is the number of people troubled by drugs and the number of crimes now linked to drug production and trafficking continue to rise. Clearly, what's been done hasn't been enough, or it hasn't been right, or, or . . . .

And now, the politicians are involved. And an agenda for 1987 is taking shape.

Cynicism, pragmatism, and idealism intact, and probably in that order, and given they'll have only one more meeting before the June, 1987 meeting, the Commission opted to push for health issues on an agenda that will emphasize illicit drug traffic and the proposed new international treaty (**The Journal**, March).

While many Commission members and observers still predict the chief item on the agenda will be political posturing, for now, they have ensured the demand reduction side, ie, prevention, treatment, research, and education, will also have a place.

They have stressed too that the program should take into account comments from governments and intergovernmental and non governmental agencies, as well as the results of such special events as the recent meeting of health ministers in the United Kingdom (see page 1), and an upcoming meeting in Stockholm of non governmental organizations, among others. Canada recommended a study by the International Council on Alcohol and Addictions of 20 demand reduction programs on five continents be included too.

What could the 1987 meeting achieve?

In December, 1985, Tamar Oppenheimer, director of the UN division of narcotic drugs and deputy to the director-general of the UN office at Vienna since 1982, was appointed secretary-general of the conference. It's a very senior UN post for the near-retirement Madame Oppenheimer; a successful conference would be a fitting finale to her 40-year UN career.

She told **The Journal**: "It (the meeting) is designed to get member states to focus on the overall problem as it affects them and to take advantage of experiences and techniques available.

National machinery

"It will be a little like going to university. Countries will get as much or as little out of the meeting as they put into it. If they don't go prepared, if they haven't looked at their own problems and don't understand the context, they may not get anything out of it.

"The point is a very major effort is being made to bring together all the available knowledge."

One of the most important effects of the meeting may evolve in the run-up to the conference, she said. And, that is the development of "national machinery."

The chairman of the Commission, the representative of Finland, agreed that the effects of preparation for the meeting may well be as important as the meeting itself. "The preparation is very important," Juhana Idanpaan-Heikkila of Finland told **The Journal**.

"We should really use the occasion to develop some new elements, both in international and national policies. And, I would like to stress the national policies.

"We have international policies, and we have the international governmental agencies — the United Nations Fund for Drug Abuse Control, the International Narcotics Control Board, and the division (of narcotic drugs). But, I would like to see something new . . . especially on the national levels. There have to be national activities."

He said for eight years the Nordic countries — Denmark, Finland, Norway, and Sweden — have collaborated. While national coordinating bodies meet regularly within each country, they also liaise regularly across boundaries. The venue for the meeting rotates country to country.

"I will say you have to work very hard and meet often and have many discussions." But, it is no longer possible to think of working without this cooperation, he said. "Yet, I don't see these activities in many countries."

The interest in national coordination is not unique to Madame Oppenheimer and the Commission chairman. Increasingly, Commission members and observers note that lack of focal points for national efforts in the field precludes effective national action and inhibits development of concerted action at the international level.

In part, the need is for health experts and enforcement officials to work together at all levels. This is the view of a growing number of international experts.

Philip Emafo, a pharmacist, Commission rapporteur, and representative from Nigeria, is emerging as a strong voice of reason in the Commission. A leading lobbyist for inclusion on the 1987 agenda of demand reduction, he emphasizes the need for coordination and cooperation between health and enforcement people.

"It is now clear that the problem will not be solved by tackling the supply system alone. There is also a need to deal with prevention, treatment, and education to reduce demand. Otherwise, it fails, as we have failed in the past.

"I am more and more convinced of the need for a relationship between those two groups — the health and the enforcement people, and that would include customs," he told **The Journal**.

That the 1987 meeting will be highly political, highly complicated to organize, and highly expensive is clear.

What is less clear is what it will change or should change — either in the run-up to or after June, 1987.

There are conflicting demands for resources. A Scandinavian observer said that in at least one Nordic country, drug problems already attract too much political attention and deflect it from the more pervasive problem of unemployment.

Another observer was en route from Vienna to a conference on child prostitution. Child labor, children at war — are also issues. As are poverty and ignorance.

For Canada, the drug field remains one "of a federal-provincial nature," much as Mila Mulroney explained it in Washington. Indeed, the note she carried last year was simply updated this year for David Kirkwood, deputy minister of health and welfare, to carry to the March meeting in London of health ministers.

But perhaps more critically, the players on Canada's international team are changing. The senior coach has left and new members are joining.

The Canadian delegation to the Commission this year was the largest ever with, as usual, officials from health and welfare and the Royal Canadian Mounted Police, but now with increasing input from the solicitor-general's office and the department of external affairs, which led the team, as well as representatives of customs and excise and the department of justice. Attending as an observer was Jan Skirrow, executive director, executive director, Alberta Alcohol and Drug Abuse Commission.

For Donald Smith, PhD, leader of the delegation for more than a decade, it was his last Commission meeting.

Dr Smith recently retired as senior scientific adviser, intergovernmental and international affairs, health and welfare.

One of the country's leading experts on international drug policy and control, he is also a former Commission chairman.

Credibility

He observed, to **The Journal**, after saying his farewell to the Commission, that Canada has achieved a high level of credibility in the last decade — at the Commission and internationally. But, he acknowledged that back in Ottawa, the international team's profile — as a team — is low and said that in his own department, he has been unable to do more.

Whether Canada maintains and build its reputation in this field, nationally and internationally, may well depend on whether strong, new national leadership emerges here in the run-up to the "university" that Madame Oppenheimer wants the 1987 conference to be.

That alone may make the conference important to Canada.

THE BACK PAGE

US official links early marijuana use to AIDS risk

By Harvey McConnell

ATLANTA — AIDS (acquired immune deficiency syndrome) and early marijuana use have been linked speculatively by Donald Ian Macdonald, MD.

Dr Macdonald is the administrator of the United States Alcohol, Drug Abuse and Mental Health Administration, the umbrella organization for the US national institutes on alcohol abuse and alcoholism (NIAAA), drug abuse (NIDA), and mental health (NIMH).

Dr Macdonald bases the AIDS/early marijuana use link partly on current AIDS research and partly on anecdotal evidence he's collected.

It has already been suggested that marijuana may depress the immune system.

Dr Macdonald told the PRIDE (Parents' Resource Institute for Drug Education) international conference here that about 26% of AIDS patients in the US are intravenous (IV) drug users whose first drug experience was with marijuana. IV drug use carries the risk of direct blood-to-blood transmission of the AIDS virus through sharing contaminated needles.

Dr Macdonald pointed out AIDS was originally seen as predominantly a disease of male homosexuals. Then, evidence surfaced linking it with IV drug users, 95% of whom were heterosexual.

He said his personal inquiries during the last year at various US institutions where AIDS patients are treated show the vast majority of them had used marijuana, butyl nitrite (by a majority of male homosexuals), and alcohol.

Experiments with mice and guinea pigs at the University of Virginia, Charlottesville, show the herpes virus given to animals also given tetrahydrocannabinol (THC) grew faster and produced more changes in interferon — a natural body immune resister — and in lymphocyte function than in control animals given only the virus without THC.

Macdonald: anecdotal

Dr Macdonald said the increase in both AIDS and herpes in the US matches the massive upswing in drug use. "We know that almost all drugs have an effect on the immune system. At the moment, we just don't have as good a handle as we'd like."

He suggested attention should be paid not only to adolescent drug users, but also to drug users of the 1960s and 1970s.

"Why hasn't there been national panic about drugs? One million people may have AIDS.

(see **Immune, p2**)

Vol. 15 No. 5 2nd Class Mail Reg No. 2776 TORONTO, May 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Developing a national policy on drug control

The centre section

By drinking half as much

Women get cirrhosis twice as fast as men

By Joan Hollobon

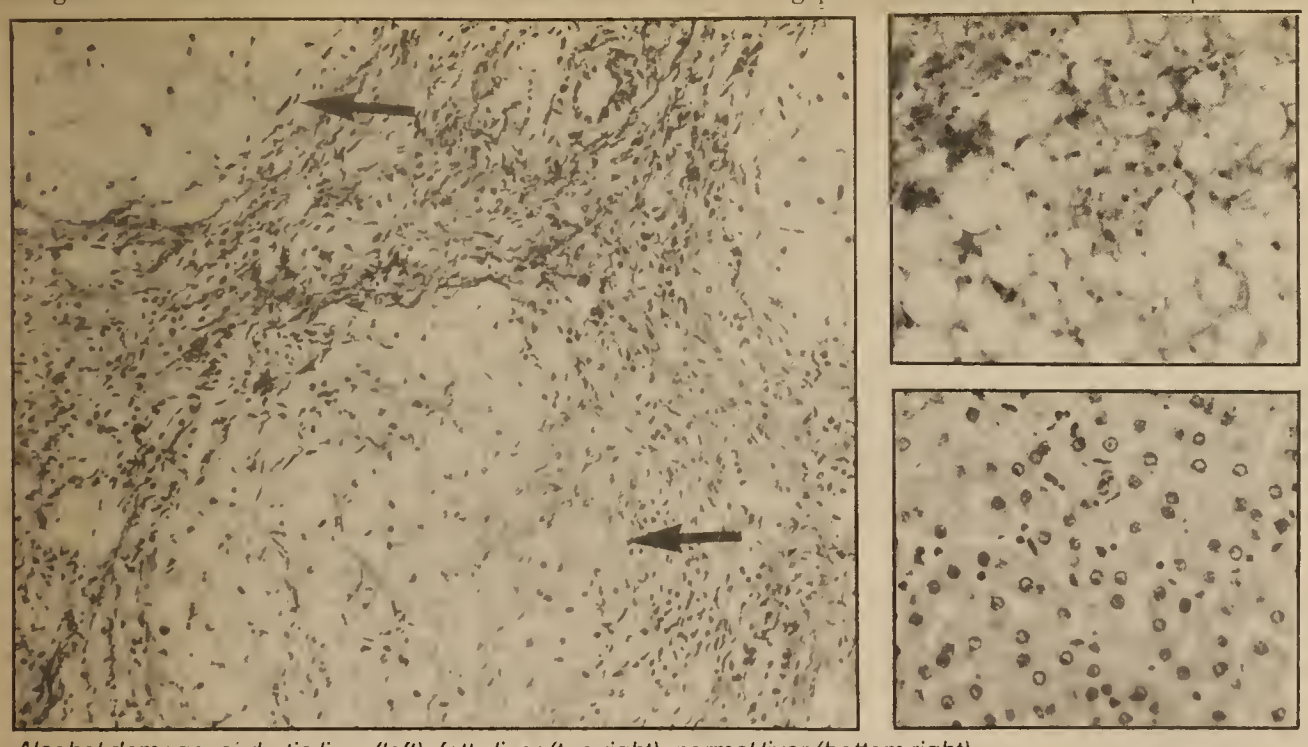
TORONTO — Women who drink heavily risk developing liver disease twice as quickly as men and on half the intake.

In men, alcohol produces "chemical castration," Hector Orrego, MD, told a symposium here on sex differences in alcohol and other drug use.

Dr Orrego cited a French study comparing the mortality index among men and women after drinking the same quantities of alcohol. At up to 20 grams of ethanol a day (two beers), there was no difference. But, at 20 g or more, the index for women was the same as for men who drank between 60 g and 80 g a day.

When women reached 80 g per day, their index was 36 times that of male drinkers. "With a quarter or half of a bottle of wine, females run the same risk as males do with a whole bottle," he explained.

Studies in Canada and Australia support the finding that women are at higher risk. In Canada, male cirrhotics were found to have consumed three times as much alcohol as their female counterparts. In Australia, scientists found women became cirrhotic after drinking half the amount in half the time required to produce severe disease in men.



Alcohol damage: cirrhotic liver (left), fatty liver (top right), normal liver (bottom right)

Dr Orrego told **The Journal** more research should be done on the physiological effects of alcoholism in women.

"Everything that has been done in males — and there's a lot now — should also be done in females. . . . We should see what the relationships are between the levels of estrogen and liver damage, for example."

In males, the complex metabolism of alcohol, part of which occurs in the testes, results in a reduced synthesis and an increased destruction of testosterone, plus an increased synthesis of estrogen, Dr Orrego told the meeting at the School for Addiction Studies of the Addiction Research Foundation (ARF) here.

One drink reduces testosterone levels for six hours, he said.

Spermatozoa production also is "dramatically decreased" — lowered fertility is well recognized among male alcoholics.

Dr Orrego: "So, in men, alcohol is equivalent to chemical castration."

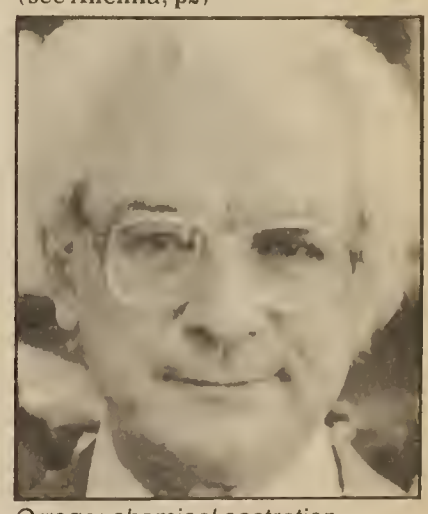
Dr Orrego is head of the ARF gastroenterology program and a professor in the departments of medicine, pharmacology, and physiology at the University of Toronto.

Ingestion of alcohol initially causes accumulation of fat in the liver, but this disappears with abstention. The next phase, with continued drinking, is alcoholic hepatitis, the "hallmark" of which is the destruction of liver cells.

Drinking can then lead to more cell destruction resulting ultimately in cirrhosis, the replacement of part of the liver structure by fibrous, nodular material.

Dr Orrego said the determinant of mortality from alcoholic liver

(see **Anemia, p2**)



Orrego: chemical castration

MDs could be potent anti-tobacco force

By Elda Hauschildt

TORONTO — Doctors must understand cures for smoking-related diseases are only 10% medical; the rest is public policy advocacy, says the man who shepherded health warnings for cigarette packages and advertisements through the United States legislative process.

And, physicians represent a "potent" political force for good in North American society, said Michael Pertschuk, former chairman of the US Federal Trade Commission (FTC).

"When it comes to matters of health, you speak with authority," he told physicians here at the first medical conference in North America on medicine and the politics of tobacco.

"As physician-citizens, you have appropriate influence. You are in a position to help make the quest for a smoke-free North America approach reality by the year 2000."

Smoking "as an acceptable social norm is defended by a formidable economic and political superstructure which includes tobacco farmers and manufacturers and those — such as the mass media — economically dependent on them.

"Unlike most public health ventures — which do not face politically organized resistance — physicians and other public health advocates have learned, slowly and painfully, that the prescriptive cure for the smoking disease is compounded 10% of medicine and 90% of public policy advocacy."

He pointed out public policy advocacy has blossomed since the mid-1960s, when the US tobacco lobby was so successful the first law covering health warnings on cigarette packages did little but protect the tobacco industry, freeing it from proper regulation.

In the 1980s, the FTC's efforts to strengthen the warnings succeeded because the public health lobby had "come of age" and "focused the intensity and energy of concerned volunteers, especially physicians and scientists, through hearings, letters, petitions, and head-to-head meetings."

Yes, smoking is addictive, p2

Mr Pertschuk said other lobbyists in the US label the doctors efforts the "golden bullets" of lobbying because the FTC was able to get four, strongly-worded, rotating warnings on US ads and cigarette packages.

Mr Pertschuk's call to action was one of several pitches made to 65 doctors from southern Ontario at the one-day conference, organized by the community health division, continuing education, at the University of Toronto's Faculty of Medicine. The College of Family Physicians of Canada accredited the course, co-sponsored by the Non-Smokers' Rights Association (NSRA), Physicians for a Smoke-free Canada, and the Addiction Research Foundation here.

David Sweanor, counsel for the NSRA, told them the public is "crying out" for leadership and lacks information on the actual toll of smoking — "30,000 Canadians killed a year.

"To be involved in smoking and health issues is to be involved politically," he advised.

Andrew Pipe, MD, founder of Physicians for a Smoke-free Canada, said the doctors should be leading, not following, social change.

INSIDE

NEWS

Briefly ...

Priestly precautions

LONDON — Clergymen here have been advised to take special precautions to prevent the spread of AIDS (acquired immune deficiency syndrome). The Right Reverend Eric Kemp, Bishop of Chichester, has reminded clergymen to make sure they wipe the rim of the wine chalice after every communicant has drunk from it, says *The Medical Post*. After the service, the cup should be washed in hot water and detergent, he adds.

To the Ritz, James

OTTAWA — Drunks and transients picked up in the downtown core here are being "dumped" by some police officers in the Rockcliffe section of this city, says *Canadian Press*. An investigation by the Ontario Provincial Police confirms a few of their Ottawa counterparts have been dropping off inebriates in the vicinity of 24 Sussex Drive, the residence of Canada's prime minister.

It's a SADD song

KINGSTON — When teens phone a local radio station here to request their favorite song be played, they're not after Bruce Springsteen or Madonna. They want *If Only I Had Taken The Time*, and the song's message is anti-drunk driving. The song was composed by a local high school band here, says *Canadian Press*, and the group, The Party Zone, is involved in the SADD (Students Against Drunk Driving) program.

Smoke-free zone

CLARENVILLE, Newfoundland — A new hospital here is the first in the province to go smoke-free. The policy decision means 200 full-time staff and all new employees will be made aware of the smoking restriction as a condition of employment, says *The Medical Post*. Current staffers of the Dr G. B. Cross Memorial Hospital will be given the chance to participate in a stop-smoking program.

Chinese suds

PEKING — China is building its biggest brewery to help quench the nation's thirst for a beverage now in short supply. The brewery will produce enough beer to provide each of this city's 10 million people with 30 bottles a year, says *The Peking Daily*. Chinese and Danish experts designed the brewery, due for completion in 1988.

Signing up

LONDON — Doctors here who fail to sign prescriptions written by receptionists could face disciplinary action. The Pharmaceutical Society and the British Medical Association will meet to help stop the illegal procedure, says *Doctor*. The society is also concerned that some physicians leave blank prescriptions in drug stores to save themselves and patients the inconvenience of repeat office visits.

Bolder stance is necessary to control international drug rings, says Turner

By Harvey McConnell

ATLANTA — Elimination of drug-refining laboratories may be the only effective way to make a dent in international drug trafficking.

"Until you make traffickers bleed, you are never going to stop the organizations," says Carlton Turner, PhD, director of the White House Office on Drug Abuse Policy in Washington, DC.

Dr Turner, here to address the annual international conference of PRIDE (Parents' Resource Institute for Drug Education) told **The Journal**: "A lot of people believe crop substitution is going to solve the problem or eradication is going to solve the problem. But, you can only go so far and so fast on these.

Turner: make them bleed

"Let's be candid. A farmer takes your money, eradicates his coca bushes, moves over the hill, and uses the money to grow more coca bushes.

"I think we have to recognize that crop substitution where the narcotic plant is grown legally — as in the case of the opium poppy and the coca bush — has to continue. But, neither it nor eradication can be the panacea many people think."

Dr Turner said there needs to be some "rethinking" about how trafficking works. In the case of the coca bush, for example, traffickers have to purchase the leaves, bring in chemicals to process them into coca paste or refine the paste into cocaine powder, and bring in transport to take the drugs out.

"Thus, the refining site is where you hit them at their most vulnerable point. At that site, they have a lot of money invested. You are not going to take traffickers out by just taking money away from them. And, you are not going to take the trafficking organizations out by seizing assets — although this will help."

Dr Turner said rethinking is also needed on how to deal with drug users. "There are certain people who want to put them in jail and throw the key away. Other people say they are destroying themselves when, indeed, they are destroying society. Urinalysis gives us a way to rethink this," he added.

Dr Turner told the conference there is increased concern in the United States and abroad about the devastating effect drug cartels have on internal and external security.

He predicts that in the next five years "there is going to be an enormous change in the international fight against drug abuse. Other nations will unite. I think we are putting drug cartels on notice that things will change."

Drugs: dreams and nightmares

Reagan's pep talk

ATLANTA — She loved the audience and the audience loved Nancy Reagan, wife of United States President Ronald Reagan, as she exhorted parents and young people at an international parents' conference here to "hang in there and we'll win" against drugs.

A few years ago, "we parents were as innocent as — in some ways, more innocent than — our kids.

"Young people taught us through their suffering," Mrs Reagan told the annual international conference here of PRIDE (Parents' Resource Institute for Drug Education).

Mrs Reagan: "Drugs take away so much. They take and they take until finally every time a drug goes into a child, something else is forced out, like love and hope and trust and confidence. Drugs take away a dream and replace it with a nightmare."

Women are more susceptible

Anemia a determining factor in cirrhosis

(from page 1)

disease is the amount of necrosis or cell destruction.

"Cirrhotics who don't have liver necrosis do not have a higher risk of dying than patients with fatty liver."

Alcohol increases the liver's demand for oxygen. Necrosis is believed to result from the combination of several factors, prominent among them a reduced availability of oxygen.

Dr Orrego said that in rats moderate anemia combined with alcohol increases liver cell destruction.

Analyses of human mortality statistics confirm the findings of the animal studies.

Dr Orrego said an analysis of anemic patients showed 80% of those with a hemoglobin of less than 75% died within a year.

Further statistical analysis of 19 variables selected anemia "as one of the most important determining factors."

Women's greater tendency to anemia may therefore predispose them to alcoholic liver disease. A United States study found 20% of non-pregnant women and 50% of pregnant women were anemic — defined as having less than 12 g of hemoglobin.

Another theory for the greater susceptibility of women to liver necrosis relates to their greater immunological reactivity.

Ethanol and acetaldehyde, an intermediate product of alcohol metabolism, both act to alter proteins, which may then be seen as foreign and subject to immunological attack. This leads to a vicious cycle of necrosis, further attack, further necrosis, said Dr Orrego.

Immune link researched

(from page 1)

And. . . . 27 million people regularly use drugs, on some basis, and many more have experimented or tried on some other basis."

Dr Macdonald wants the message to get to IV drug users "that if you get off the needle now — even though you are infected (have a positive HTLV-III virus test) — you are going to greatly reduce your chances of getting AIDS."

He says evidence now accumulating suggests to him that if he had a positive HTLV-III test, "you wouldn't see me with a glass of wine or a joint (of marijuana)."

Dr Macdonald later told **The Journal**: "The immune link is not so easy to prove" which is why $13.9 million (Cdn $19.07 million) is being spent this year by the US government on such research.

While no one is ready to say butyl nitrite causes Kaposi's sarcoma (a disease often affecting those with AIDS), "we know it is related."

Yes, yes, and yes again — smoking IS an addiction

TORONTO — How did scientists decide cigarette smoking was an addiction?

They answered three questions in the positive, Lynn Kozlowski, PhD, told doctors here at the first medical conference in North America on the politics of tobacco.

"Yes, cigarette smoking is drug taking. Nicotine is a drug its users like to take . . . in part, for the effects it has on their brains.

"Yes, it is difficult for the user to stop. Nicotine does produce withdrawal effects, but the extent to which withdrawal effects are the cause of the difficulty in stopping use is unclear. If it is a factor in compulsive use, it may vary greatly from individual to individual.

"Yes, it is addictive. But, is it really as addictive as heroin? Comparing nicotine and heroin is like comparing apples and watermelons. My best guess is that these drugs are in the same ballpark of addictiveness, and nicotine could very well be more addictive (more susceptible to compulsive use) than heroin — all things being equal. Of course, all relevant factors will never be equal in human studies on these drugs."

Dr Kozlowski is associate professor of preventive medicine and statistics at the University of Toronto and head of behavioral research on tobacco use at the Addiction Research Foundation here.

— coming up in —

THE JOURNAL

- **MDMA — a look at the drug and its consequences**
- **Tracking international collaboration on drug abuse**
- **More on sex differences in alcohol and other drug use**
- **A researcher's diary: the private lives of two pioneers**
- **Canadian customs service — stemming the drug flow**
- **Search and seizure: case histories**
- **A week in the life of Ontario**

NEWS

Triplicate forms for doctors' use

Pharmacists offer plan to cut script forgeries

By Maureen Brosnahan

WINNIPEG — The Manitoba Pharmaceutical Association (MPhA) is recommending physicians issue all prescriptions in triplicate on specially numbered forms, in an effort to cut double doctoring and prescription forgeries.

Ron Guse, assistant registrar of the MPhA, said this would ensure better tracking of prescriptions and discourage drug abusers from trying to forge prescriptions or visiting several doctors to obtain prescription drugs.

Mr Guse told **The Journal** the system would involve writing prescriptions on numbered triplicate forms. The doctor would keep one copy while the patient would take the other two to the pharmacist. The pharmacist, on filling the prescription, would keep a copy and send the third to a central office where all prescriptions could be reviewed weekly.

Mr Guse said this would be an improvement on the present system, under which Canada's Bureau of Dangerous Drugs is able to review prescriptions and doctors' prescribing habits every two to three months — often, when it's too late to track an abuser.

He said the new system would take a more preventive approach to prescription fraud.

"It would give us feedback on who's playing the game," he said.

This system has been used in the United States, particularly Texas and Idaho, with good results, Mr Guse said. And, Alberta pharmacists introduced the plan this spring.

In Texas, he added, statistics show there has been a 52% decrease in illegal or improper use of narcotic prescriptions since the system was implemented.

The new concept has been endorsed by the Manitoba College of Physicians and Surgeons. Jane Stewart, spokesperson for the Manitoba Medical Association, said doctors are also in favor, provided they don't have to foot the bill for the new prescription forms.

Mr Guse said the next step will be to convince the provincial government and to begin discussions with the various groups on how to implement the program.

Debate persisting on medical heroin decision

By Joan Hollobon

TORONTO — The Canadian government decision to allow heroin use for severe pain control was not based on scientific opinion, Michael Spino, PhD, a University of Toronto associate professor in pharmacy and medicine, told the 8th annual conference on Drugs and Geriatric Care here.

He said "the overwhelming majority of opinion clearly shows" morphine is as effective a narcotic as heroin for pain control in cancer or in other severe pain conditions.

"It isn't clear to me what the reasons were for that (the government decision) . . . it is clear to me that it is not based on scientific opinion." (**The Journal**, November, 1984.)

Heroin, in fact, is quickly metabolized to morphine, he added.

Blood monitoring shows that after the initial dose of heroin there is "a rapid peak in the serum, which probably gets into the brain a little bit more quickly. But after 15 or 30 minutes, all we are seeing in the blood is morphine," Dr Spino said.

He conceded that "an individual is, in fact, an individual," and there are a very few cases in which some people respond to one analgesic and not to another for reasons as yet unknown to science.

There may, therefore, be exceptional individuals who get more pain relief from heroin, but the question is whether this justifies "adding this greatly abused drug to the open marketplace," Dr Spino said.

Dr Spino said the elderly take more drugs than younger people; one 1981 study in the United States shows 11.4% of people aged 65 years and older receive 31% of all prescription medications. (See Stats•Facts page 9.)

Codeine and combination oral analgesics represented the most frequently prescribed drug category, with anti-arthritic drugs (nonsteroidal anti-inflammatory drugs) in second place. In addition, the US *National Diseases and Therapeutic Index* recorded that 30% of people older than 65 years reported using aseetylsalicylic acid (eg, Aspirin) at least once a week during a one-year period.

Narcotics may be accompanied by more profound adverse effects in elderly patients than in younger people, Dr Spino warned.

Narcotics may cause greater respiratory depression and postural hypotension in old people, probably because a given dose produces a higher serum concentration owing to the smaller volume of distribution and to the decreased ability of the elderly to eliminate the drug from the body.

The elderly, therefore, require only about two-thirds of the milligram per kilogram dose of morphine given to younger patients.

'Black tar' heroin from Mexico creates risk of more US addicts

By Harvey McConnell

WASHINGTON — A potent form of heroin processed by farmers in three Mexican states poses a risk the number of addicts in the United States might increase significantly.

A study by the US Drug Enforcement Administration (DEA), said that the heroin — called "black tar" because of its dark color — is a danger because of its high purity, low price, and widespread availability. Black tar heroin first started to appear in 1983 in four southwestern US states bordering Mexico. But, it has now been seen in at least 27 US states.

Overdose deaths have probably been caused among heroin addicts because of the higher-than-usual purity of the product, the DEA report says.

It is probable black tar heroin is available in all established Mexican-US communities in the US. Illegal immigrants and migrant workers are the main source of supply.

The heroin is produced and processed by amateurs in the Mexican states of Durango, Sinaloa, and Sonora. It can be sticky — like tar — or can harden to the consistency of a lump of coal.

INSIDE OUT

Paradise — on a clear head

All week long, down in the sun and away from the winter, I'd wondered if I would wander from the path.

The trip was, for me, a test case. Could I go to a rum-soaked Caribbean island — the way I always used to do back when time seemed endlessly joyful with its promises of perpetual parties — and somehow stay sober?

Would I be able to hang happily around as hundreds of suddenly palm-crazed Canadians gulped pina coladas and other drinks so sweet their devious kick was almost disguised?

More importantly, would I have any fun at all, seeing sunsets spreading over the sea, with merely a resolutely clear head as a witness?

I tell you, I prayed a couple of times. For insurance, you understand. I felt I had a lot at stake. This holiday was, one way or another, going to answer some hard questions.

Well, I made it. Made it through all the way, better — much better — than any fantasies I could have concocted. Indeed, it was one of the sweetest trips ever taken, down there, to paradise. And, I knew it, and each day I felt stronger, more confident, even — by the end of our stay — giddy in my freedom.

So, I was still high, when the plane landed back home. I was humbly thankful too, and I said another prayer then, a prayer launched for a different reason.

And just one day later, my head still fixed on those sunsets, my feet still stuck in the sands of a happy memory, the Great Doubt arrived in my living-room — astonishingly, instantly, irrationally, from out of nowhere. I really wanted a drink.

(Did I temporarily, madly, believe my 'triumph' in the Caribbean had made me finally graduate from the school of alcoholism and, thus, suddenly able to handle booze once again?)

It passed quickly, mercifully. But, it scared me, down to the bones.

It was a ferocious need I hadn't truly felt for months and months, but there it was, staring me in the eyes, daring me to say: "Yes, yes, just one . . . ."

Well, I made it through that, too, and the same afternoon, a few hours after the momentary panic, there I was on my way back to where it all began for me — that tremendous adventure I'm still on.

Did I believe my triumph made me a school of alcoholism graduate?

I was returning to the clinic. This time it felt quite strange taking the familiar elevator up to the fourth floor again. Outside, the weather was exactly as it had been when I had first come myself for help: bitter, gloomy, cold, empty of all promises of paradise.

I was returning to welcome some new troops coming in for rehabilitation. My friend, a counsellor, had agreed when I had offered before my holiday to show up and talk a little about what I'd been through and what the newcomers might expect in the next three weeks.

So, laughing now at my weakness, chuckling at the irony, I, who'd just had a big scare, got out of this elevator with mixed feelings. I'd been all set to tell them how great they'd feel if they stuck with the program, how charged with meaning their lives would be, how blessed even the upcoming, inevitable pain would loom later down the road. It was true, too, of course. Oh, it was so true. I was still smiling as I watched the parade come in.

There was Charlie, the host for the evening. He sat behind the desk, efficient, wise, warm. He had seen it all before. He had been there before. He was a rock.

A newcomer came in, suitcase in hand. He asked if he should take some pills or wait until the next day. Wait, Charlie advised. The man looked extremely nervous, but he was eager to get on with it. He went to the washroom to provide a urine sample.

I walked down the corridor, past the pamphlets I'd almost memorized when I was there. I looked into a classroom. Two young men watched television. Everybody — it hit me, with full force — was equal here. It was a democracy, as pure as an algebraic concept. I got a coffee and was glad to see it hadn't changed at all.

In the foyer, another man came in, carrying a shopping bag containing all his hopes and despair.

Suddenly I thought: I love it here. Remembering this, remembering how it looks, just might keep me sane, all the way through. This was, in a profound sense, my roots. Now, I was ready to talk to someone.

Charlie looked up at me and told me to sign in. Sign in! He thought I was a newcomer, too, and wasn't he right? I told him I'd already done my time, I was here to speak to the group.

"Well," he said, "they won't all be here until maybe 11 o'clock. Why don't you do it one-on-one?"

I looked around. A man about my age came in. He looked *simpatico*. I introduced myself, asked him if he wanted a coffee, and we went into a quiet room. I told him about myself, about the program, and the counsellors. I tried. His eyes grew colder.

"I'm not in here for booze," he said, without emotion. He said he'd been a counsellor himself, years before on skid row. "They've got no brains," he said. "I hate booze."

I could sense the mounting tension. He was a big man. He'd been using drugs for two decades, he went on. Cocaine was his thing now. One of his acquaintances had just had his "head blown off." He paused. He didn't care what happened to him, he said. Life, death — all the same. I nodded, I believed him.

"I hate shrinks," he added. He'd leave the clinic, he said, head for the streets, if something or someone rubbed him the wrong way.

I believed him again. Implicitly.

I was glad when another man came in to join us. He seemed amiable, well-spoken, and he looked in a good mood. He'd just gotten out of jail — been there for a few months. Impaired driving. Again. Said he didn't think he had a big problem with booze, didn't see why he couldn't use it "moderately" again, once he got out of here. He was very pleasant.

Later, he admitted he'd been in trouble "hundreds" of times before because of booze. He was very cheerful. No problem, he exuded. Who's got a problem? Not me, buddy. I can handle it. I can handle it. I can handle it. . . .

He almost had me believing him, too. Implicitly.

It's what I told myself for years, until much of my world fell into pieces.

I said goodbye then, wished him luck, and got back on that familiar elevator, going down, back down to reality, where I can still see sunsets spreading across the sea, with a clear mind.

This column, exploring addictions from the "inside out," is by a freelance Canadian journalist.

NEWS

RESEARCH UPDATE

Pregnant women's OTC drug use a concern

In the past two decades, women have learned to stop drinking and, to a lesser extent, to avoid smoking during pregnancy. But, they are still taking over-the-counter drugs in sufficient quantities to be of concern, says a Scottish study. Researchers at Stobhill General Hospital, Glasgow, prospectively recorded the drugs taken during pregnancy by 2,765 women attending the antenatal clinics of the hospital between October, 1982 and March, 1984. While 93% of the women avoided exposure to drugs during the first trimester, 65% took no drugs throughout the entire pregnancy. The remaining women took 154 drugs from 35 groups — mainly non-narcotic pain-killers, antibacterials, antacids, or antiemetics. The study also found 65% of the women abstained totally from alcohol during pregnancy, and a similar percentage did not smoke. Study results were compared with a similar survey conducted in Edinburgh 20 years earlier, which until now had been the most recent other survey of drug use during pregnancy in Great Britain. The researchers found a general reduction in drug use of all kinds (particularly antiemetics) during the first trimester and in barbiturates and diuretics during the whole pregnancy. In addition, there was a substantial reduction in alcohol consumption in the more recent study group. However, there was a less dramatic reduction in the number who smoked during pregnancy. The study concludes since little is known about clinical pharmacology during pregnancy, "the extent of cigarette smoking, the use of self-administered analgesics, and the relatively common administration of drugs clearly not necessary for maternal health are matters worthy of further attention."

British Medical Journal, January 11, 1986, v.282:81-83.

Evidence lacking on infant cocaine withdrawal

Maternal cocaine use cannot be linked to withdrawal symptoms in newborns similar to those seen with other narcotics. That is the conclusion of a small study of eight infants born at the University of Irvine Medical Center, Irvine, California. Their mothers gave a history of cocaine abuse and the infants had positive urine tests for cocaine following nursery admission. Researchers from the department of pediatrics said that on evaluation, only one of the infants manifested any symptoms ordinarily associated with neonatal drug withdrawal. These symptoms were "transient, required no therapy, and were not considered attributable to withdrawal." Two of the infants were considered small for gestational age. The researchers conclude: "The fact that no evident, potentially life-threatening symptomatology was noted in this group . . . lends some initial comfort and suggests we are not in need of management strategies in the initial care of these infants, as has been necessary in instances of heroin abuse." But, they caution the study group is small, and cocaine withdrawal symptoms in adults are difficult to assess in newborns.

Pediatrics, February, 1986, v.77:209-210.

Weight gain linked to smoking cessation

Swiss researchers think they have the answer to why smokers tend to weigh less than non-smokers and gain weight if they stop smoking without decreasing their caloric intake. A recently published study by the four researchers from the University of Lausanne demonstrates an increased energy expenditure in smokers that would account for these differences. Using eight healthy, volunteer smokers, the researchers evaluated energy expenditure of the subjects while confined to a respiration chamber for 24 hours. On one test day, they smoked 24 cigarettes at fixed intervals; on another, they refrained from smoking. The researchers found cigarette smoking produced a 10% increase in the subjects' overall, 24-hour energy expenditure from a mean of 2,230 kilocalories to 2,445 kcal. This increase was observed in all the subjects and lasted during the night after the cigarettes were smoked. The study also shows smoking was accompanied by a 20% increase in average heart rate and a 45% rise in urinary excretion of norepinephrine. The researchers said the increase in energy expenditure "was clearly sufficient to account for at least part of the well-established differences in body weight between smokers and non-smokers." They said the findings also help explain why people gain weight if they stop smoking without decreasing their caloric intake.

New England Journal of Medicine, January 9, 1986, v.314:79-82.

Teens deny drug use as health problem

A significant number of Canadian adolescents are drinking, smoking, and using recreational drugs, but they do not view their habits as health concerns. A 1983 random survey of 1,000, 12 to 20 year olds in the Ottawa area, in the form of a mail-in questionnaire, was conducted by researchers from the department of pediatrics, University of Ottawa, the Children's Hospital of Eastern Ontario, and the Social Sciences and Humanities Research Council of Canada. Asked to indicate health concerns that worried them, more than 25% indicated concerns about acne, emotions, teeth, being overweight, and, among girls, menstrual periods. Only 1% of the 729 respondents said alcohol problems, and only 2% said problems with other drugs. Similarly, few said they considered their alcohol or other drug use important emotional or social problems. Yet, 49% said they drank alcoholic beverages regularly or 'once in a while.' This rose to 89% for those aged 18 years or older. And, 15% said the same of recreational drugs. While only 16% of the males said they smoked cigarettes, more than twice as many females, 35%, did

Canadian Medical Association Journal, March 1, 1986, v.134:489-493.

Pat Rich

Vancouver gives go-ahead to smoke-free workplaces

By Heather Walker

VANCOUVER — This city became the first in Canada to provide smoke-free workplaces when amendments to the city's health by-law came into effect recently.

John Blatherwick, MD, Vancouver's medical health officer, told **The Journal** the by-law's provisions against smoking in the workplace are based on similar by-laws in several United States cities. "We looked primarily at by-laws in San Francisco and Minneapolis/St Paul for the sections regarding the workplace because there are no similar by-laws in Canada."

While the by-law will not prohibit smoking in the workplace under all circumstances, it gives non-smokers the upper hand — eliminating smoking entirely where there is a dispute between smokers and non-smokers.

"It's a soft by-law, but with a big hammer," Dr Blatherwick said. "Employers can designate smoking and non-smoking areas, but if there is a disagreement, the employer is supposed to ban smoking in the workplace."

Dr Blatherwick said he does not expect the by-law will be difficult to enforce. "We looked at the (US) experience, and they had very little problem with enforcement. In Minneapolis/St Paul, there was only one intervention, and in San Francisco, it was almost as easy."

The by-law will also make smoking illegal in most public places here. Smoking will be outlawed in cinemas, theatres, libraries, retail stores, bank lineups, hospitals, clinics, medical and dental offices, all public and government buildings, pools and other indoor sports facilities, and display areas in museums and galleries.

The by-law provides for fines of $50 to $2,000, plus $50 per day for continuing offences, for those breaking the law or failing to enforce it.

Restaurants, hotels, lounges, and bars will be allowed to designate smoking areas, and smoking will also be allowed in up to half the area of "personal service establishments" such as hairdressers, barbershops, and health spas, as long as the facility has a seating capacity of more than 10 people.

Smoking will also be prohibited in elevators and stairways and will be allowed in taxis only if all the passengers and the driver agree.

Dr Blatherwick said the amendments not relating to the workplace were "a consolidation of all the by-laws from across Canada." Most Canadian cities have by-laws prohibiting smoking in public places, he said.

"I call these first generation by-laws. It's hardest to provide a smoke-free environment in the workplace.

"But in Vancouver, 75% of the adult population do not smoke, and this is the way to go to prevent irritation and possible health hazards for non-smokers."

Staff commitment key to treatment success

Credentials don't guarantee quality

WASHINGTON — The personal commitment of drug abuse workers offers the only guarantee of quality service for patients.

Credentials and certificates are necessary to protect the public, but more than that is needed, says Karst Besteman, executive director of the Alcohol and Drug Problems Association of North America (ADPA) here. These points emerged at a recent ADPA-run United States policy forum on the issues of quality assurance.

Besteman: alert and alive

"You need the structural indications, by having credentials or being certified, that there is a concern shown about quality," Mr Besteman said.

"But, the other side of the coin is that when you come to work you give it your best shot; you take the time to keep yourself professionally alert and alive, and your clinical director and chief executive officer are committed to the delivery of service and not just the bottom line — 'are we in red or black ink?' "

Credentials and certificates have their place. "Being a degree-certified social worker, being a PhD in clinical psychology, being a board-certified psychiatrist does not make you an effective therapist, but it does eliminate some people who shouldn't ever be," Mr Besteman said.

And, having a hospital which has the approvals needed for third-party reimbursement does not say, "This is the best treatment centre." The consensus is that individual commitment, particularly by the administration, is the most important ingredient.

One should listen to the patients who have recently been in treatment.

Mr Besteman: "I think most patients quickly recognize when they are being given something inadequate and I think most patients are wise enough to walk away from it if they are not.

"Programs which are known for their quality have tremendously active alumni who are almost passionately committed to the welfare of that program by telling people about it."

Caution needed in 'ecstasy' trials

By Harvey McConnell

WASHINGTON — Animal studies indicate the drug "ecstasy" has a neurotoxic potential in humans, and any trials with it must be done with extreme caution.

The warning follows studies at the University of Chicago by Charles Schuster, PhD, and L.S. Seiden, MD. Dr Schuster, new director of the United States National Institute on Drug Abuse here, presented his findings at a seminar shortly before his appointment.

The "ecstasy" findings arose out of studies on the neurotoxicity of amphetamines and their derivatives.

Drs Schuster and Seiden and other investigators have shown that repeated administrations of high doses of d-methylamphetamine produce a long-lasting depletion of monoamine neurotransmitters in the brain.

They continued their studies with investigations of MDMA (3,4 methylenedioxymethamphetamine), or "ecstasy," given twice a day for four days in varying doses to rats via subcutaneous injections.

Two weeks after drug treatment ceased, tests showed serotonin levels in the brain were reduced with the highest drug dose producing the highest reduction (88%) from control values.

Dr Schuster said damage to the nerve cells containing serotonin is crucial as they are involved in regulating functions such as sleep, aggression, sexual behavior, and eating.

He and Dr Seiden said MDMA has not been systematically investigated for its effectiveness in treatment of behavioral disorders, and evidence of its efficacy is weak as there have been no appropriate studies — including double-blind trials.

The potential for benefit in any clinical trial must be weighed against possible side effects. So far, Drs Schuster and Seiden conclude, trials of MDMA on humans should only be done with the utmost caution, or only if researchers are convinced the potential benefits are great enough to outweigh the risks.

GILBERT

Richard Gilbert has been in China. His column will resume next month.

NEWS

They develop sophisticated denial systems early

Kids of alcoholics need pre-teen help

VANCOUVER — Children in alcoholic families need help before they're nine years old. Otherwise, they may learn patterns that will lead them to become alcoholics themselves, says a United States specialist.

Claudia Black, PhD, told the 1st Western Conference on Drug and Alcohol Abuse here: "If you're serious about wanting to address alcoholism, you need to be serious about wanting to address children, because they're going to be our future alcoholics." She said 60% of alcoholics are raised in an alcoholic family setting.

Dr Black, who operates the Alcoholism, Children, Therapy consulting service in Laguna Beach, California, said the problem is not finding children of alcoholics, but rather "committing ourselves to resources for children."

She said when she started treatment programs nine or 10 years ago, family therapy for alcoholics did not include the children. "It's only a family program if children are a part of that process."

These children do not set out to become alcoholics, she said. The opposite is true. But during childhood, they learn the kind of denial patterns that keep people with alcohol problems from admitting the problem and seeking help.

Young children in alcohol-troubled homes develop a denial system "as sophisticated as that of the alcoholic," she said.

"By the time they are age nine, 10, and 11, while they may in fact not deny the drinking, they certainly deny the perceptions. And, they're already denying how they feel in response to what is taking place."

Dr Black said the denial is so successful that "40% of the kids who leave an alcoholic home at the ages of 17, 18, or 19 years have yet to identify that's what it is that has taken place in their life." Many still see alcoholics as derelicts and do not equate this with the behavior of the alcoholic parent or parents.

Many are also confused and lack the resources to cope.

They may be tired because of constant strife at home. They may be ill from internalizing the stress of trying to cope, and they are often not fed appropriately.

In addition to the physical problems, children from alcoholic homes also have fewer social, academic, and spiritual resources. Dr Black said one study shows that only 27% of children of alcoholics are willing to confide in a friend when they have a problem, compared with 68% of other children. They have trouble focusing on their school work and they lose faith in the ability of others to help them.

Dr Black: "I find that children do whatever they need to do in order to bring a sense of predictability into their lives, a sense of stability, a sense of reason, or a sense of order."

Children often feel embarrassed or think they are betraying their parents when discussing parental alcoholism with therapists.

"We need to teach children they're not betraying their parents," Dr Black said, but rather they're betraying the disease, or that part of the parent which is sick.

Therapists must also explain to the child exactly what is happening. "We're going to need to make sense of their experience for them in order for them to be able to talk to us. . . .

"The purpose is to help children no longer deny, discount, or rationalize, (all of which) is the basis from which the alcoholic family operates.

"(Therapists) need to teach the children how to undo the denial process, otherwise they will continue in their lives, minimizing, discounting, and rationalizing their own feelings — which I believe is a set-up for their own chemical dependencies."

Black: betraying the disease

Alcohol treatment model fine for coke addicts

VANCOUVER — Ninety percent of what is known about treatment of alcoholism can be successfully applied to cocaine addicts, says David E. Smith, MD, founder and medical director of the Haight-Ashbury Free Medical Clinic in San Francisco.

"If you understand alcoholism theory and practice, you understand 90% of what you need to know to deal with cocaine addiction. You just need to brush up on toxicity and epidemiological and socio-cultural characteristics of the problem.

Smith: a different track

"You don't need a whole different cocaine treatment system to deal with this cocaine epidemic," he told the 1st Western Conference on Alcohol and Drug Abuse here.

However, Dr Smith said, it's important for those who treat cocaine users to be aware of the characteristics of the drug in order to gain credibility with patients.

"If you're an alcoholism counsellor and somebody comes in and says, 'I'm freebasing two grams of cocaine a day,' and you say, 'What's freebasing?' — you're going to turn them off."

Dr Smith said health professionals must not make the same mistake as cocaine abusers who create a mystique about cocaine. This happens if therapists don't keep up-to-date.

Those who treat cocaine users should remember the lesson of alcoholism treatment: individual psychotherapy is not the treatment of choice. Most cocaine addicts are treated in this way for paranoia, depression, and anxiety.

"We don't have to go down that track again," Dr Smith said. Effective psychotherapy is not possible while the patient is continuing to use the addicting drug.

"The best and most effective treatment of cocaine addiction is abstinence and recovery-oriented treatment strategies, with everything else added on."

Dr Smith said 60% of cocaine addicts have a family history of alcoholism or other drug dependency — the same statistic given by Claudia Black, PhD, to show the percentage of children of alcoholic parents who became alcoholics themselves. (See story above.)

Dr Smith: "In fact, if I wanted to ask one question that would predict whether initial experimentation would proceed to addiction, or whether the person would discard the drug, it would have to be (does) the person have a positive family history of alcoholism?"

Clonidine reduces preoccupation with the craving for a cigarette

By Lynn Payer

NEW YORK — Clonidine hydrochloride reduces the craving for cigarettes induced by short-term withdrawal significantly more than either placebo or a diazepam-like (eg, Valium) sedative, a study here suggests.

Alexander Glassman, MD, professor of clinical psychiatry, College of Physicians and Surgeons, Columbia University here, reported the study results to the World Congress on the Pharmacologic Treatment of Tobacco Dependence here.

Dr Glassman said 21 heavy smokers, who averaged two packs of cigarettes per day, were asked not to smoke anything on the day they joined the study. They were given either clonidine, a sedative, or a placebo on three different days, separated by at least seven smoking days. (The sedative was used to control for the sedative effects of clonidine.)

When asked to give a global rating of how much each substance helped them not to smoke, subjects rated clonidine more effective than the sedative, which they rated more effective than the placebo.

"What they were rating was their preoccupation with smoking — their thinking about smoking," Dr Glassman said.

He explained that on measures of anxiety, patients receiving clonidine and the sedative had similar ratings, with both drugs differing from placebo. Clonidine was therefore not acting solely as a sedative; it may act on the locus ceruleus in the brain, which is thought to play a major role in attention or vigilance (**The Journal**, May, 1985).

Since clonidine reduces withdrawal syndromes associated with opiates and alcohol, Dr Glassman said, "it offers both the possibility of an alternative pharmacological aid to smoking withdrawal and raises the question of the role of the noradrenergic system in withdrawal syndromes in general."

HOWELL

Angels' tears on the tongue

On its Easter Sunday edition, the CBC (Canadian Broadcasting Corporation) business news program *Venture* reported Carling O'Keefe brewery hopes to rescue its flagging fortunes by introducing a foreign beer to the Canadian market.

Since every major Canadian hrewery has tried this little trick in recent years, to the point where just about all the readily recognizable United States and European brands — Carlsberg, Amstel, Guinness, Lowenbrau, Budweiser, Miller, Coors — have already been conscripted to fight the Canadian beer wars, Carling O'Keefe had to dig deep to find a suitable foreign brew.

Digging deep, Carling O'Keefe found what it wanted Down Under. So, it is once more into the breach, my friends, this time with that all-time Aussie favorite, Foster's Lager.

Eat your heart out Labatt's (or sip your insipid Budweiser); tremor in your boots Molson's (or languidly lap your Lowenbrau), beeause here comes a foreign beer so distinet, so unique, that to say it is a brew *pas comme les autres* is to make the understatement of the year.

You doubt me? Well, ye of little faith need only heed the words of *Venture* host Patrick Watson. Mr Watson reports Carling O'Keefe plans to advertise Foster's Lager in Canada as "the beer that taste's like angels crying on your tongue."

Think of it. Angels' tears. Right on your own tongue.

It would appear the Canadian heer drinker has a real treat in store for him or her. I say "it would appear," because there have heen regrettable occasions in the past when imports have not lived up to their billing. Some Budweiser imhibers were never able to detect the Beechwood in Bud, and some Coors consumers were hard-pressed to identify the Pure Rocky Mountain Spring Water in Coors.

But, those brews came from the secular, decadent US. Foster's Lager comes from a country where heer is a religion, and the plan to resurrect Carling O'Keefe's market position with angels' tears was announced on Easter Sunday, by an award-winning Canadian journalist. One must have faith.

But having faith, there are still practieal considerations. This beer is obviously sacramental, but how should one accept the sacrament? Obviously, one cannot be so gross as to chug-a-lug the lachrymal leavings of gossamer-winged heavenly helpmates. So, what does one do when presented with a Foster's — does one extend the tongue reverently as at a Mass? Of necessity, we must look to Carling O'Keefe for guidance on these matters.

And, what will angels' tears actually taste like anyway? A vexing question that, especially in view of the fact that the age-old argument as to the numher of angels that can dance on the head of a pin has never been satisfactorily resolved. Will they taste like the milk of the Holy Virgin (Liebfraumilch wine) available at liquor stores? Probably not — holy lactation is one thing, holy lachrymation quite another. Will they taste like the tears of Christ (Lachrimi Christi) also availahle at liquor stores?

One would suspect there might he a certain resemhlance between angels' tears and the tears of Christ hut one cannot be sure.

In the absence of any indication from Carling O'Keefe as to just which type of angel (seraphim, cherubim, or archangel) actually produces the tears, this question can never be answered with finality. So, ultimately we must await the reception given by Canadian beer drinkers to Foster's Lager for definitive answers.

And keep the faith in the meantime. That means being beware of false prophets such as Michael Jackson — not the singer, the editor of the coffee-tahle book *The World of Beer* — who claims Foster's Lager heer is "characterized by its malty full-hody, sweetish taste, and uncompromisingly pale color" and makes no reference whatsoever to its resemblance to the lachrymal products of celestial celebrities. What does a guy with a dumb name like that know? Would you trust him rather than Carling O'Keefe? Be reasonahle.

By Wayne Howell

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Covenant likes section on street kids

I just read the excellent pull-out section The Journal did on the street is no place for a kid symposium (April).

How can one say thank you for coverage such as this? Joan Hollobon did a fine job — it's accurate, sensitive, and thought provoking.

Michael Knight,
Covenant House
Toronto, Ontario

Smoking, a constant irritant

I read with interest Richard Gilbert's column (January), which included comments on cigarette smoking. Being a non-smoker and working in an office that has a ratio of almost 50% smokers to 50% non-smokers, I am somewhat comforted to know that the problem is at least being addressed. It is not at my workplace, even though it's a federal jurisdiction and Treasury Board guidelines apply.

The World Watch Institute's suggestion that "banishing cigarette use in the presence of non-smokers should be considered a minimum level of protection" makes a lot of sense. Smoke is a constant irritant. Mix it with noxious fumes from automobile exhausts, and you have double the trouble.

Dr Gilbert's earlier columns on tobacco from February, 1979 to the present would make interesting reading, so I would like copies please. Also, **The Journal** appears in our office now and then, but not consistently. I would appreciate it if you would include me on your mailing list. Thank you.

A. Hamilton Rostic
St Catharines, Ontario

Medical education concerns NZ reader

I think **The Journal** is excellent.

Here in New Zealand, I am concerned that although there are many organizations which educate the public regarding the dangers of alcohol and other drug abuse, it appears that many of the people in these organizations have only a superficial idea of the problem — yet set themselves up as experts.

I think emphasis should be put on the family or spouse of an addicted person so history doesn't keep repeating itself.

An interesting exercise for you would be to find out how much time in medical schools is devoted to teaching about alcoholism. *(Ed note: A 1984 survey by the Ontario Medical Association showed that the province's five medical schools spend no more than 0.5% of teaching time on addictions, even though 10% of the patients in the students' later practices will have alcohol and other drug problems* [**The Journal**, August, 1984].)

I have tried to find the answer to that question here in New Zealand from our health minister with no success.

I think the only response a lawyer, doctor, or health professional should give when a family member complains of alcoholism in the home is "get help for yourself and family." Investigation should then be carried out to make sure there is adequate help available, by adequately trained people.

Pat Butler
Nelson, New Zealand

Not the 'good life'

Beer ads mislead youth

As a moderate smoker and drinker, I know much has been said regarding tobacco ads and the fact they should be banned because of health hazards to oneself and to others.

"Smoking kills" may be appropriate. But, what about the multi-million dollar ads in the press, radio, television, and sports promotions which relate to beer commercials?

The incidence of death caused by drunk driving is staggering. Drunk driving is both self-destructive and kills others.

Smoking or drinking is everyone's prerogative, but I believe they are synonymous. The "good life" of beer commercials is surely educating youth in a misleading and dangerous manner.

S. H. Routbard
Kingston, Ontario

Articles, info are excellent

This is to acknowledge receipt of the February, 1986, edition of The Journal.

I am always happy to receive your excellent publication and enjoy very much the articles and information it provides.

I encourage you and your staff to keep up the good work, and I look forward to receiving future issues of The Journal.

Joseph Cordiano
MPP, Downsview
Legislative Assembly
Toronto, Ontario

Thanks for TJ

Thank you for **The Journal**.

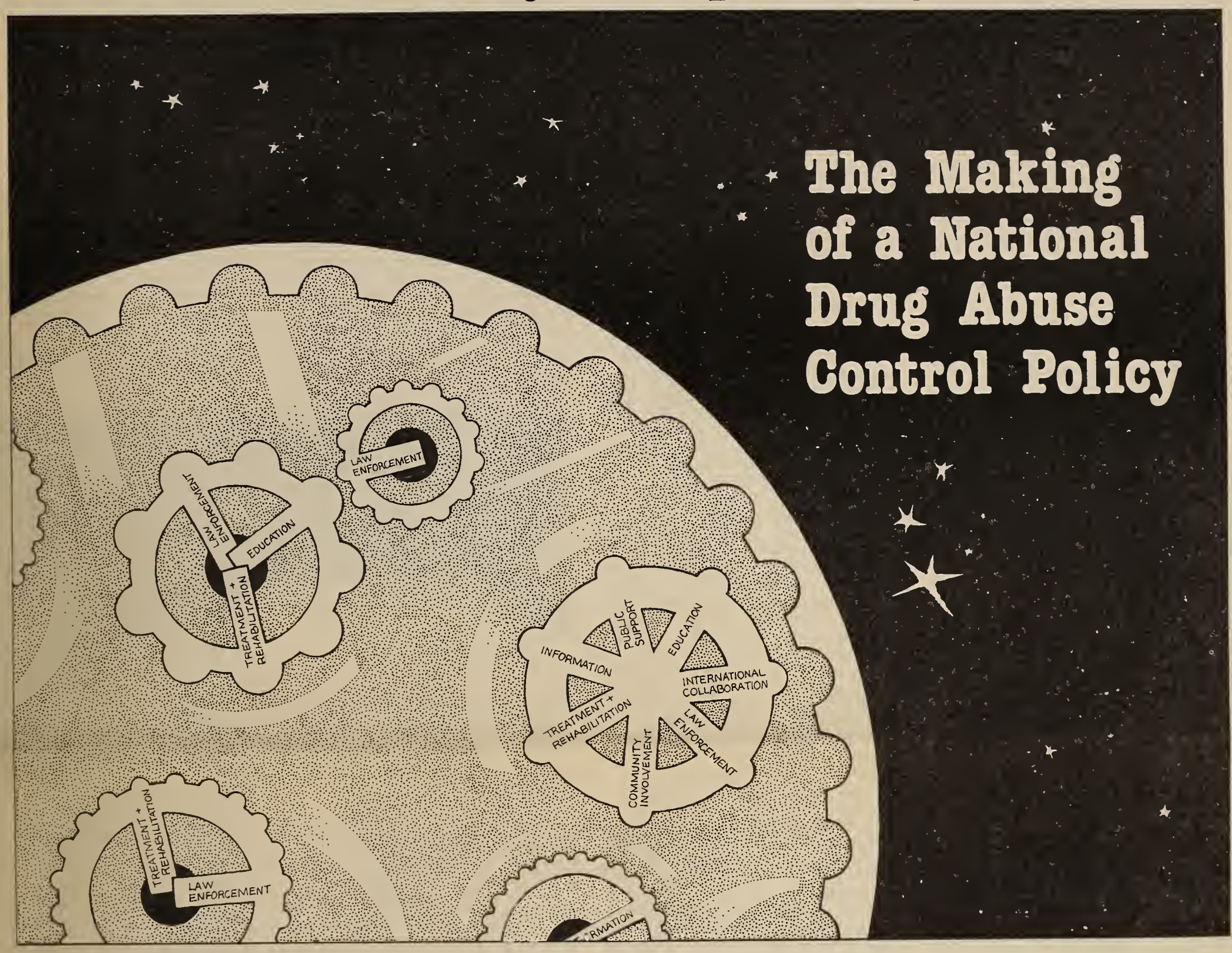
It is full of good information not available elsewhere.

I am particularly interested in public education as it relates to alcohol and other drugs.

Stephen Hart, MD
Nashwaaksis Medical Clinic
Fredericton, New Brunswick

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of the sender may be sent to: **The Journal**, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

FROM: The Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse



Information, education, community action, treatment, rehabilitation, and law enforcement — health and enforcement programs — are integral to drug abuse control at local, national, or international levels.

For decades, health and enforcement specialists from countries around the globe have worked together through such bodies as the United Nations to contain international drug abuse and trafficking.

Increasingly, however, those specialists see a need for more and better cooperation betwcen and among their peer groups in their own countries.

As well, the international community is stressing the need for better-coordinated anti-drug efforts in individual nations, for the good of each country, as well as the good of the world community.

The pressure on countries to act is expected to build during the next year, as plans move ahead for the world ministerial-level meeting on drug abuse and trafficking scheduled for June, 1987 (The Journal, March).

Bror Rexed, MD, is a former director-general of the National Board of Health in Sweden and a former member of the UN International Narcotics Control Board. He retired in 1982 after four ycars as executive director of the UN Fund for Drug Abuse Control.

He describes the building of a national anti-drug policy in a paper commissioned by the UN World Health Organization for the Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse, which was held in London in March (The Journal, April).

Contributing editor Karin Maltby has condensed Dr Rexed's paper for readers of The Journal.

Rexed

The setting

The world is dominated by a minority of industrialized nations, where relatively well-educated people live in reasonably secure situations in welfare societies. The majority of these people enjoy a satisfactory standard of living, with a high consumption of everyday goods. Even increasing unemployment has not changed this situation. More than ever before, people from these countries travel abroad, and fashions and lifestyles spread rapidly across frontiers.

New attitudes to drug-taking make up part of this situation. Social structure is changing, with a reduction in the birth rate leading to smaller, nuclear families and young people starting to live independently at an early age. Religion's hold on people has loosened, and the philosophy of life is materialistic, with more than a touch of hedonism.

The developing world is heading toward the same future. Even in the poorer and less-developed countries, sections of society show strong lifestyle similarities to industralizcd countries. There is always a supply of cheap drugs — even for the poorest people. Although in less-developed countries there is still a difference in social structure — a tradition of larger families and a stronger attachment to religion — many young people follow international changes in attitudes and fashion.

Opium, alcohol, and other dependence-producing substances have been used and abused for a very long time, but the demand for narcotic and psychotropic drugs has increased steadily since World War II. This demand has been generated by the interaction of material, technological, and cultural changes and fed by a growing illegal production of — and traffic in — narcotics and by misuse of a rapidly increasing number of synthetic substances. In many countries, demand is fuelled by persuasive trend-setters who talk of freedom, mind expansion, and innocent experimentation.

So, drug abuse is perceived everywhere as a problem, to a lesser or greater degree and in many diverse forms. There is growing concern. Governments are now likely to be willing to take national and international action — indeed, there are signs of growing political will to fight drug abuse.

The complexity of causes and other factors has resulted in diverse types of abuse in different countries. Fortunately, however, this situation is simplified because prevention programs can be built with basic elements.

Internationally, the spread of drug abuse may create a feeling of pessimism, but there are countries where abuse is still small scale, countries where the number of abusers has been stabilized or reduced, countries where resistance by young people to drug abuse has become stronger.

The fight against drug abuse is in no way lost. The first priority is to stop recruitment by counteracting new forms of abuse and concentrating efforts on creating interests and activities centred on healthy lifestyles, especially for young people. The fight against drug abuse will be won in families and on school playgrounds and college campuses of the next generation.

Continued on page M2

The Making of a National Drug Abuse Control Policy

Principles

Any national policy is a set of decisions to follow courses of action aimed at achieving defined goals. All nations have basic beliefs, traditions, and experiences which influence the direction and range of new proposals.

Drug misuse and abuse are terms describing behavior which is difficult to explain and even more difficult to influence and prevent. In framing a national drug abuse control policy, it is important to clarify basic assumptions and experiences that will govern policy development, including these precepts:

- **There are no swift solutions.** The causes are complex, and trends in abuse change slowly; policy planners need to develop long-term, continuing efforts so they don't create unrealistic expectations.
- **Giving in is not a solution.** Liberalizing drug use and decriminalizing offences lead to more extensive abuse. Such policies sacrifice the young, who like to experiment, and socially-weak, at-risk groups, who are hardest hit by abuse.
- **Progress is marked by partial success.** Japan stopped central nervous stimulant abuse after World War II, the United States curbed heroin abuse in the 1970s, and Norway and Sweden cut down on drug use by the young in the 1980s.
- **Prevention is the main goal.** The first priority is to stop recruitment by demand reduction and lower abuse by supply reduction. Treatment, rehabilitation, and social assistance are always one step behind any increase in drug abuse.
- **The abuser is an individual in distress.** The abuser has chosen the wrong solution to his or her problems; the first impulse should be help and support, not punishment.
- **Drug abuse is a behavior problem.** Complex causes must be defined and solved. The drug used is secondary to the behavior problem and serves only as a means to an end.
- **All dependence-producing substances are dangerous and harmful.** Experimental and leisure drug use implies a risk of dependence and misuse. Heavy abuse, including alcohol abuse, causes health damage and social malfunctioning. Terming drugs 'light' or 'heavy,' 'soft' or 'hard,' is misleading, prompting inadequate policy solutions.
- **The long-term goal is to free society from non-medical drug use, minimizing abuse.** Unacceptable drug use (eg, heroin, LSD) and misuse of legal therapeutic drugs (eg, barbiturates, tranquillizers) must both be eliminated. Illicit use often begins with overuse, promoted by lax attitudes to therapeutic use.
- **Public opinion must oppose non-medical use of drugs.** Preventive action must counter discussions and behavior that further drug misuse. In most countries, a majority of the population opposes dependence-producing drugs for traditional and religious reasons. However, the fight against alcohol abuse is waged against a background of accepted, socially favored use.
- **Community-level action minimizes adverse health and social effects.** Prevention efforts are more effective at the 'grassroots' level — families, schools, cultural and political societies, etc.

Initial considerations

Drug abuse starts with an individual misusing a drug in a social context. This triad — substance, individual, society — can be used to explain any abuse situation, although the emphasis on elements will vary. Analysis of drug abuse within a country will indicate the elements of preventive action needed and start discussion of a national policy.

Developing a broad policy

A preventive national policy must cover a broad spectrum of actions to reduce supply and demand — information campaigns, education, community movements at the grassroots level, treatment and rehabilitation, support of law enforcement by police and customs, international collaboration on control of illicit drug trafficking — because abuse has multiple causes involving the characteristics of various substances, individual psychology, and social risks and pressures.

National efforts in one, isolated area of this broad spectrum will not solve a country's drug problems. Priorities and concentration of effort will vary, but the entire range of prevention efforts will be needed in a concerted action. A national plan should be based on a central policy objective which has significance for all sectors of the spectrum.

When the United Nations Commission on Narcotic Drugs (CND) designed an international strategy for drug control in 1981, it outlined these objectives: improved drug-control systems, a balance between the demand for and the supply of narcotic and psychotropic drugs for legitimate purposes, eradicating drug supplies from illicit sources, reducing illicit traffic, reducing demand for illicit drugs and preventing inappropriate or illicit use of licit drugs, and treatment, rehabilitation, and social reintegration of drug abusers.

Continuing the policy

A national policy, when defined, should be a continuing one, repeatedly affirmed and successively developed through monitoring and evaluation procedures.

Panic actions are especially damaging to public support. Any country affected by widespread abuse is likely to go through a period of sudden awareness, characterized by hysterical over-reactions from various groups. Systematic collection of epidemiological data on the type and extent of drug abuse is necessary to reach a mature stage of broad policy planning.

Equally damaging are sudden trend changes in national policy. With systematic analysis and planning at the outset, few cases of policy reversal are defensible.

It is quite a different matter, however, to advocate an adaption, over time, of a national policy on the basis of monitored collection of experiences and evaluation of the results. Such periodically instituted trend changes should not break the continuing general development of prevention efforts and should be in line with established goals.

Another risk is to lose momentum in implementing a policy because of a feeling that more knowledge might be necessary to be sure of the best, long-term option. Drug abuse control is often a fight against illegal and clandestine behavior. Action has to be taken on evidence that, from an ideal viewpoint, would be deemed insufficient. Even so, it is often more dangerous to stay passive, conducting more research, than to act on the basis of prudent analysis of existing data.

Instant, dramatic results are unlikely. Long-term, concerted actions are required to deal with complex, often-changing problems. It is especially dangerous to allow a pessimistic attitude — engendered by slow results — to open the way to liberalizing the use of dependence-producing drugs.

Action programs

Organization

Experience shows there is a need for high-level, governmental organization to plan a national policy and monitor its implementation. The political, historical, and administrative background of a country will have a decisive influence on the form the organization takes. Two levels may be involved.

A first and rapid review of drug abuse problems and measures for their immediate control may be the responsibility of a commission of inquiry, of a committee, or of a national commission. This review should be achieved within a set time limit and provide the basis for the initial government decisions on policy.

Continuing policy formulation requires an organization within government, eg, an intergovernmental committee of ministers under the chair of the prime minister or the deputy prime minister, an interdepartmental committee presided over by a minister, or a committee representing the government authorities involved, presided over by a minister.

There is a need for a permanent, functioning, central organization responsible for planning, implementing, and monitoring a national policy. As a first step, this group should review national drug problems, leading to a plan for immediate control action.

Epidemiological studies

A national policy must be based on knowledge of the types and extent of drug abuse problems. The first information may be fragmentary and not collected systematically, but — as soon as possible — more consistent, planned data collection should be instituted, even in a simple form. This process should be continued through development of systematic epidemiological studies in parallel with policy development. Epidemiological data-collection schemes must be planned to create continuing series of data to make it possible to verify trends of abuse. Such studies will help monitor and evaluate the programs planned.

A central administrative unit should be organized in an appropriate ministry to plan, standardize, evaluate, and survey studies of drug supply and drug abuse in the country.

Legal drugs

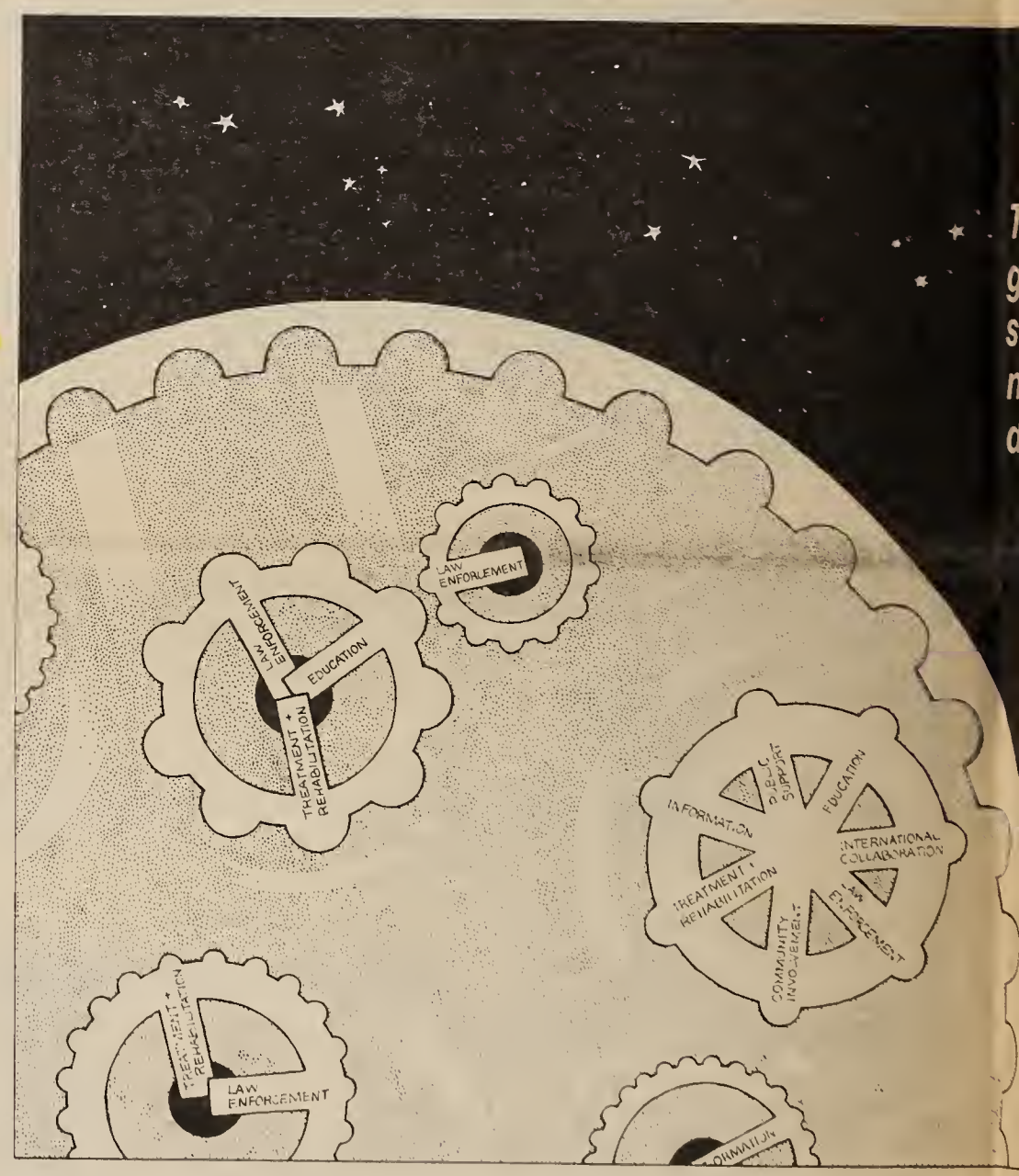
A nation's drug legislation tries to ensure the required supply of safe, effective drugs of good quality. However, for dependence-producing, psychoactive drugs, there is the risk of abuse, necessitating special controls under international conventions. Use of such drugs is thus limited to medical and scientific purposes, and, in the majority of cases, they can be dispensed only under medical prescription. Over-the-counter sale is permissible only in certain, specified conditions, in low doses, and in small quantities.

Notwithstanding these safeguards, drugs believed to be innocuous are found, in practice, to give rise to abuse, and drugs known to be dangerous are overprescribed and overconsumed. The greater the consumption of such drugs, the larger will be the number of people abusing them — whether they are available through licit dispensing or illegal trafficking.

Many countries control these drugs more strictly than international conventions require. Other nations still possess outdated, incomplete legislation.

The registration and distribution of psychoactive drugs should be part of an effective, national system applicable to all medicinal drugs and under the guidance of a competent health administration, including a drug-control laboratory. Drug evaluation and selection can then function on the basis of adequate information provided by manufacturers and importers.

All countries limit the number of psychoactive drugs available for use, and the World Health Organization (WHO) has identified a 'common core' of some 30 drugs as a universally relevant and applicable selection for basic health needs.



A necessary adjunct to regulation of psychoactive drugs by health authorities is continuous surveillance of supplies and use. International studies have been published by the International Narcotics Control Board (INCB). Nationally, studies should include manufacturing supply data, import statistics, product sales by industry, studies of prescribing and dispensing physicians and pharmacies, and general utilization surveys.

Health care professionals — especially physicians — are responsible for everyday distribution. They are important in preventing overuse and misuse, as well as the diversion of these drugs to illicit traffic. They should always be informed of new developments in psychopharmacology and relevant therapy and participate in continuing education on the rational use of psychoactive drugs.

Physicians should inform patients about the aim of therapy, the effects of the drug, and possible adverse reactions. But, sources of additional information also need to be available to the patient (eg, package inserts). Generally, health education should be actively used to give the

public the facts on health maintenance and medical treatment of disease. It should be possible to warn people in general about the dangers of careless or excessive use of psychoactive drugs. Advertising of such drugs may be strictly controlled or prohibited.

Demand: types of abuse

The demand side of the supply and demand equation is complex. Drug-taking behavior (the demand) is multifactorial, changes rapidly — individually and collectively — and is greatly influenced by social setting. Abuse takes many forms, engaging groups of different ages and social situations. All of them need support to break the habit. Different actions are necessary to prevent others from becoming abusers. Epidemiological studies will define various groups within different countries, but some forms of abuse are seen in many nations, in varying degrees of importance, as noted below.

• Youth and drug problems

Adolescence is often a period of stress and frustration. The passage from childhood into maturity may involve crises in relation to parents, teachers, and the opposite sex. It is easy for young people to be overcome by feelings of the general meaninglessness of life as they view the world situation.

To be esteemed by one's friends is important, and behavior is adjusted to one's peers. Commercialized fashions promote the use of tobacco, beer, and wine. Glamorous images of the drug culture are sometimes found in media and in music, minimizing the dangers and giving the young hope of self-understanding and mind expansion. It's not surprising young people start experimenting.

Cannabis preparations are preferred substances. The young age and immaturity of most cannabis users, coupled with experimental and recreational nature of use, characterizes a situation in which prevention requires understanding and a positive approach. Restrictions and stronger law enforcement may be counter-productive.

A change in attitudes to cannabis use has been seen in the US, France, The Netherlands, Norway, and Sweden, with first experimentation at an older age and fewer users. The common denominator in this trend seems to be credible information and active opinion-building.

Further actions to reduce demand include educating children in schools, informing parents about drugs, supporting parent groups, initiating mass-media campaigns, supporting youth organizations which provide healthy leisure activities, increasing outreach of social workers in depressed areas, and providing appropriate training for professional groups engaged in fighting drug abuse.

• Sniffing among children

Although sniffing of substances causing some kind of euphoric or exciting reaction does not involve the use of ordinary, dependence-producing drugs, there is still a relationship between the two phenomena. Substances involved are those used in everyday life — glues, fat solvents, cleaning liquids, and gasoline.

Abusers are youngsters in late childhood to early teens, and the behavior spreads from experiments with school friends to a wider circle in school or among street gangs. Preventive action is needed. There is risk these children will later abuse cannabis and other drugs.

Possible actions include giving teachers time for increased attention to the children involved, informing the children about the dangers of sniffing but avoiding frightening or sensational presentations, increasing resources for social work with families of sniffing children and organizing after-school activities for all children in affected neighborhoods, and informing shop owners who sell abused substances about the situation and warning them not to sell if there is suspicion of abuse.

• Destructive drug abuse

The most destructive effects of drug-taking, producing the most serious health impairment and social malfunctions, are seen in people who use high doses of dependence-producing drugs.

One country has defined such users as those who inject heroin or amphetamine, or who smoke cannabis daily in high doses. These are drugs abused heavily in many parts of Western Europe, Japan, Australia, and North America. Methaqualone in southern Africa and coca paste smoking in South America are other examples.

The majority of these abusers have long histories of drug-taking and are in dire need of both physical and psychiatric treatment. Many have found a new identity through drugs and refuse treatment because of this and fear of the discomfort of withdrawal. The cost of drugs forces most of these abusers into illegal activities and petty crimes, causing public disorder and considerable losses to ordinary people.

Action to cope with such destructive abuse must be varied, reducing demand by introducing information and education programs in schools, the family, media, and voluntary organizations; establishing methadone programs when public disorder necessitates quick withdrawal of large numbers of abusers from street drug traffic; expanding differentiated, voluntary treatment programs and restricting compulsory treatment to people with marked physical and mental dysfunctions; engaging primary health care workers in community mobilization, contacting and identifying people with drug problems and guiding them to appropriate places for support and treatment; structuring treatment programs for early identification, social reintegration, educational upgrading, vocational training, and job placement; and, organizing therapeutic communities offering treatment and rehabilitation as a new direction in voluntary care.

• Cocaine abuse

Today, cocaine abuse probably constitutes the most dangerous threat for the future. Populations of producing countries already suffer from heavy abuse. Abuse in North America continues to increase. Cultivation in South America is flourishing, expanding rapidly and spreading into new countries.

Illegal traffic provides large profits; new routes to Europe and other parts of the world are found. If this trend continues, the price of cocaine may come down, possibly with significant effects on consumption.

Actions to reduce supply and demand may include clarifying the epidemiological situation by special study projects in more countries, informing psychiatric specialists and physicians on early identification of symptoms and sequelae of cocaine abuse, planning information campaigns to reach population groups at risk, intensifying law enforcement collaboration in the international field, especially in uncovering economic assets from cocaine trade, and providing strong support for coca eradication projects and integrated rural development plans in South America.

Consumption of illicit drugs

Availability of illicit psychoactive substances is difficult to track. Epidemiologists use incomplete information to put together as realistic a picture as possible. The most important information about supply is derived from law enforcement seizure records which provide an indication of the types of substances misused. Quantities seized indicate the volume of illicit consumption, but the figures must be interpreted with caution since an unknown quantity escapes controls.

Important additions to national data are international seizure statistics and information collected by the International Criminal Police Organization (Interpol). International illicit traffic and the role of illicit drugs in drug abuse is reviewed annually in the reports of the CND.

Dependence-producing substances that fall under international drug control treaties are listed in the Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol and the International Convention on Psychotropic Substances, 1971.

In ratifying the Conventions, national governments have accepted the responsibility of limiting the use of controlled substances exclusively to medical and scientific purposes and undertaken to prevent illicit cultivation, manufacture, traffic, and consumption.

While virtually the whole world has ratified the Single Convention, only about 80 countries have acceded to the psychotropic convention. *(Ed note: Canada has not.)* Voluntary reports on the manufacture and trade of psychotropic substances are, however, increasingly given to the INCB.

Possible action to support prevention programs includes the dissemination — preferably biannually — to central and local authorities of the analysis of actual trends of illicit drug demand, illustrated by national and international law enforcement data.

Supply: abused substances

• Illicit cultivation

Illicitly cultivated substances in international drug traffic include what may be called classical narcotics — opium, heroin, cocaine, and cannabis.

The cultivation areas of such substances have much in common. They are found in isolated and economically backward regions characterized by poverty and lack of development.

Crop substitution and integrated rural development schemes have been attempted for up to 10 years, with success in some restricted areas of poppy cultivation. Such projects are only beginning in the coca bush cultivation region and have not been tried at all in the countries where cannabis is cultivated.

Attempts at eradication of illegal crops have been made in some areas, with ecologically acceptable herbicides available for such efforts. Support of the cultivation countries attempting such projects is necessary to safeguard the livelihood of the poor and to train enforcement personnel.

Actions to achieve supply reduction include supporting crop substitution and rural development projects, with efforts made to persuade the World Bank and the Organization of Petroleum Exporting Countries (OPEC) to take part; supporting enforcement, including eradication in parallel with crop substitution; initiating regionally organized aerial surveillance of new cultivation in areas adjoining traditional cultivation countries; and, deploying liaison law enforcement officers in more places to speed up control of international illicit traffic, in collaboration with Interpol.

• Synthetic drugs

Industrially manufactured psychoactive substances are numerous; new drugs are synthesized at an increasing rate by scientists in industries and universities. Some are of non-medical value and too dangerous to be used, while others are medically useful and widely prescribed. These substances are controlled under the two international Conventions.

Synthetic, dependence-producing substances enter illicit traffic in different ways.

Licit, medically useful substances are produced in large quantities and sold to many countries. In various quarters of the world, abuse has, however, developed, and an illicit demand exists.

Drug traffickers use forged import and export documents, buy through non-existent companies or post-box addresses, and use the open market in countries not yet party to the Convention on Psychotropic Substances to divert licit production into illegal channels.

The INCB regularly publishes examples of such manipulations to draw attention of the national control authorities to existing loopholes. Such diversion of licit drugs evidently reaches considerable proportions.

Substances also enter illicit traffic through manufacture in illegal laboratories. This applies especially to dangerous substances without medical use (eg, LSD, PCP, and some amphetamine derivatives). Abuse of these compounds is fairly widespread in North America, whereas their abuse has diminished in Europe.

Illegal laboratories have been discovered on both continents, however, and cases of abuse are reported internationally. Illegal manufacture of amphetamines is possible in simple laboratories. Some employees in the legal industry use the employer's facilities for illegal manufacture, without the knowledge of owners.

In the US, chemists in clandestine laboratories have manufactured so-called "designer drugs" for street sales. These substances are such close analogues of illegally used and sought-after, dependence-producing drugs that they have the same or even stronger potency, but are in fact chemically legal. In some cases, unforeseen toxicity has caused illnesses and death (**The Journal**, January).

Actions to achieve supply reduction include striving for universal ratification of the 1971 Convention; striving for universal acceptance of voluntary estimates, import-export declarations, and additional statistics under that Convention, recommended by the CND, and collected and analyzed under the aegis of the INCB; collaborating with health authorities of developing countries with personnel and financial constraints to enable them to promulgate laws and regulations and set-up offices to control manufacture and international trade, thereby fulfilling their responsibilities under the international Conventions; and, supporting projects for training and equipping customs and police personnel in detection and identification of synthetic narcotic and psychotropic substances in illegal traffic, along with projects to establish analytical control laboratories to service national law enforcement authorities.

The INCB, UN Division of Narcotic Drugs, Interpol, and the Customs Cooperation Council (CCC) are the relevant advisory organizations.

Continued on page M4

FROM: The Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse

The Making of a National Drug Abuse Control Policy

A new convention

Because of increased global problems with illicit drug production, traffic, demand, and use, the UN General Assembly requested the CND to prepare a draft convention against illicit traffic in narcotic and psychotropic drugs (**The Journal**, March).

The CND commented: " . . . The adverse effects of that traffic now extended from threats to the health and well-being of individuals, to the subversion of public order, the spread of corruption and criminal conspiracy, and in parts of some regions, threats to national security and the structure of society. . . . Many national enforcement agencies were now at a considerable disadvantage in terms of human, financial, and other resources, as compared with trafficking groups, which were progressively increasing both their professionalism and their illegally acquired resources . . . ."

The General Assembly also asked the UN secretary-general to report to its 40th session on the implementation of this resolution.

There seems to be general agreement among governments on the need for new instruments against illicit drug traffic. Such instruments may complement the relevant articles of the existing international treaties. The drafting of the convention has begun. When completed, the convention might be adopted by the General Assembly. Before it can come into force, the convention must be ratified by a certain number of governments. This may be a fairly rapid process, given the general interest in the matter. To be effective, however, it has to be ratified by a large majority of states, and this may take years.

During the intervening period, it would seem important for as many countries as possible to take appropriate measures along the lines of the projected convention.

Actions to achieve supply reduction might include extending certain law enforcement activities in areas such as traffic on the high seas, in commercial carriers, controlled delivery, and smuggling through the mails; monitoring and licensing of trade in chemicals and precursors used in illicit manufacture of narcotics and psychotropics, prohibiting import where there is no need; controlling more effectively economic assets derived from illicit traffic; facilitating extradition of traffickers; and, increasing international collaboration against traffic across frontiers by strengthening Interpol and the CCC, assisting transit states, providing standard identification of controlled drugs, expediting transfer of samples of seized drugs, giving investigative and judicial assistance, and providing training and technical assistance.

Implementation

Policy formulation presupposes successive stages of development, planning, and implementation. A chain of reasoning that takes into account the current nature of drug abuse phenomena and the measures available to influence them requires basic information. This is concerned first with the prevailing forms of drug abuse, specific problems, and trend changes. Second, it is necessary to determine the availability of personnel and financial resources in order to estimate the ability to design practical programs.

Third, since implementation is always subject to constraints, priorities must be set early, indicating a time limit for full implementation of the program. Various options must be considered and activities divided into initial actions and those needed for short-, medium-, and long-term fulfillment of policy goals.

In any country, a national drug abuse control policy will start from a number of functioning institutions with staff and equipment. It's assumed there are already laws and regulations on drug control, that there exists a law enforcement and customs organization, and there are functioning medical and rehabilitation systems.

The next step is to design programs in detail. Expectations of their impact must be realistic, specific goals should be defined for each authority or agency involved in implementation, goals should be defined through a consultative process, appropriate objective criteria should be selected for measuring the outcome of the programs, and a strategy statement should be prepared to provide guidance for each collaborating agency.

Ideally, essential elements of such a statement include general objectives, goals, a concise statement of priorities, general responsibilities of each participating party, and the time and description of the major phasing of the program.

Levels of implementation

A national policy cannot be successful in isolation, but will have to support international collaboration. A number of UN organs, self-governing specialized agencies, and intergovernmental organizations have been created to serve such efforts.

• National government

A national government is the initiator, planner, and coordinator of a country's drug policy. And, to a large extent, it also finances and executes it. The first requisite for fulfilling this responsibility is to organize a central policy-formulating organ working in or with the government. It is advisable to delegate the operative responsibilities for individual programs to relevant authorities, institutions, local communities, and voluntary organizations.

The strength of a national policy will depend on how much support that policy mobilizes in local communities and citizens.

• The professionals

The execution of most programs involves professionally trained people. It's important to obtain their support and help them acquire the knowledge they need.

Groups participating in programs have different training backgrounds and different knowledge of drug abuse phenomena. Among such groups are lawyers, law enforcement officers, administrators, health service personnel, and social workers.

Each group needs information on the abuse situation, the characteristics of drugs abused and of different groups of abusers, government decisions concerning actions against abuse, and a summary of the national policy.

The central coordinating organ may distribute information on these issues to professional or labor organizations within these groups and ask them to present the data in a suitable form and context to their members. Continuing education is important for these groups in the form of training schools, *ad hoc* courses, and study material.

• The local community

No policy campaign against drug abuse can be successful without the support of local communities and the public.

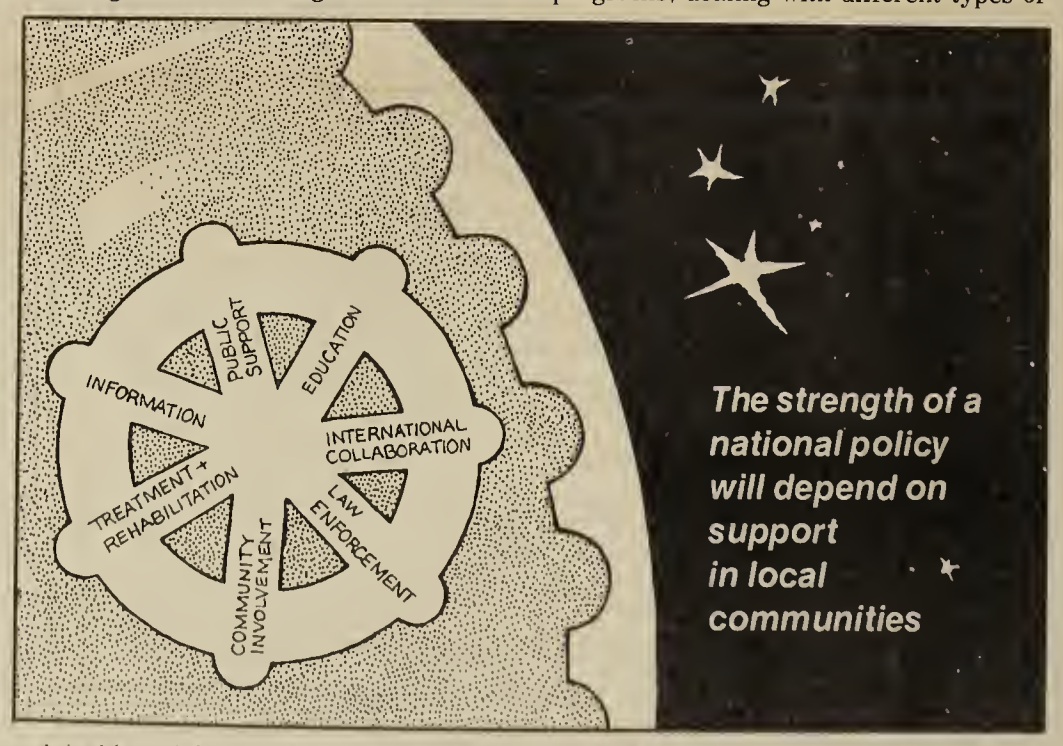
Local political authorities should evolve plans for investigating drug abuse in the area. Such knowledge is easily derived from collaboration among school leaders, child and youth social service units, law enforcement organs, and local authorities.

Voluntary organizations can contribute general information to increase awareness of existing drug problems and create understanding among the public of the type of prevention action necessary. Organizations involved in youth-leisure activities are especially important, as are parent groups.

The grassroots (the general public) can also be activated. Support of influential personalities — pop musicians, sports stars, well-known socialites, and politicians — at publicized events is extremely useful. Positive attitudes to drug-taking in the mass media or in other contexts should be forcibly attacked. Public opinion should be against the non-medical use of drugs in favor of alternative, health-positive lifestyles.

Monitoring policy

An effective national policy should be implemented in a broad range of special programs, dealing with different types of control and prevention activities.



Evaluation should be applicable to all parts of the action plan and should be conceived as part of the systematic process of developing an overall program. Through evaluation, data is collected on implementation and can lead to better planning in the future.

Monitoring and evaluation provide feedback which helps strengthen a program's effectiveness. Indicators for systematic measurement and appraisal of results should be specified. Many prevention activities and achievements are not easily measured, and their impact on the drug abuse situation cannot be quantified.

The complexity of the drug scene is an evident difficulty. The totality of a national policy can only be evaluated in the long-term against the background of reliable, continuing epidemiological analyses of national drug abuse trends.

The ideal monitoring and evaluation situation may be sketched as follows. In designing each program, appropriate objective criteria should be selected for measuring outcome and results. While each program is being implemented, communication channels should be opened between those who carry out the program and the policy-making body. Special regard should be paid to difficulties encountered. Finally, the functioning and outcome of the programs should be reported to the policy-making body.

The evaluation may be performed by program staff using some form of monitoring or outcome indicators, or by outside evaluators. The latter method may provide a greater degree of impartiality but is more costly. Simpler methods of monitoring and evaluation should be preferred if they are deemed sufficient. Flexibility is essential.

Information programs may be evaluated in a simple way with questionnaires designed as a form of market research to test whether the message has been understood and retained. At the opinion-forming level, results of a prolonged information or teaching campaign can be tested by opinion surveys on resulting attitude changes. It may even be that behavior changes can be measured by, for instance, studying the use of relevant services or changes in workloads of institutions.

The efficiency of law enforcement measures is more difficult to ascertain. Because of large 'dark areas' of illicit behavior, changes in quantity of seizures, for instance, allows for two interpretations: an increase might indicate greater efficiency, but might also be a cue to a larger illicit flow of the drug: a decrease might be due to diminished illicit traffic or less active law enforcement work. Evaluation has to follow a common-sense course of informed opinion, taking into consideration indicators from other areas of drug abuse control.

Medical treatment, rehabilitation, and social reintegration following different methods of interventions are notoriously difficult to evaluate because of differing opinions on outcome criteria and diagnoses. Scientific literature and international experience, as collected through studies by specialized agencies, probably give the best available guidance for program selection. The outcome will have to be judged by the personnel implementing the program in regular reports on results.

Assessment of drug abuse through epidemiological investigations is an important part of the national policy. A number of fairly simple methods can be used, but more refined methods are also available.

A basic precondition is to ensure representativeness of the sample investigated and the validity of the data obtained. The use of different assessment methods in elucidating a certain situation can serve to corroborate the results. Investigations repeated at regular time intervals may give evidence on the degree of reliability of the method.

International drug abuse control programs are almost always subject to planned monitoring and evaluation. In any case, countries contributing to multilateral and bilateral programs should always make sure checks on the efficiency and results of the project are instituted.

Finally, it should be emphasized the evaluation of the totality of a national policy for drug abuse control and prevention is essentially a political affair. It can usually be undertaken only after several years and as part of the formulation of a new policy.

Dr Rexed's paper is one of seven provided by the WHO to brief health ministers prior to their March meeting. In an upcoming issue, **The Journal** *will present a second paper,* ***Narcotic and Psychotropic Drug Problems: International Collaboration on Health Aspects****, by H. David Archibald, president of the International Council on Alcohol and Addictions. A bibliography for Dr Rexed's paper is available to readers. Write:* **The Journal**, *Addiction Research Foundation, 33 Russell Street, Toronto, Canada M5S 2S1.*

Market saturation in North America rebounds in Europe

Amsterdam braces for a new influx of cocaine

By Donald Hadden

AMSTERDAM — Although heroin remains Holland's and Western Europe's major drug problem, availability is making cocaine a serious threat.

Cocaine in quantity appeared on the streets here about five years ago. Since then, its use — and the problems associated with it — have grown rapidly. Now, offers of cocaine can be heard as frequently on Amsterdam's Dam Square or along its main street, Damrak, as offers of hash and marijuana.

Says J.P. Koek, a volunteer worker in the Church of Paul's drop-in centre for drug addicts in Rotterdam: "Five years ago, we saw only heroin problems. About three years ago, we began to see people with visible coke addiction problems, and heard of freebasing for the first time.

"In my opinion, cocaine is far more dangerous than heroin; it's highly addictive, and they (addicts) are harder to handle because coke makes them hyper."

In the short time cocaine has been available, it has established itself as a drug with a wide appeal. Street workers here at the Medical/Social Service for Heroin Users *(Junkiebond)* — all of whom are ex-addicts or now on methadone — keep close watch on the drug scene.

"The old users," one worker says, "still want heroin or methadone, but the new starters are using coke. Everybody wants cocaine now."

J. van Straten, director of the Central Criminal Information Service (CRI) of The Netherlands, confirms the cocaine market is growing. He does not agree, however, that cocaine will eclipse heroin as the major drug problem, as has happened in the United States.

"It will be a big problem, but hopefully not as big a problem as heroin . . . my opinion is that they are the same problem."

At present, there are an estimated 20,000 heroin addicts in Holland. In Amsterdam, the official number is 8,000 to 10,000. But, workers at *Junkiebond* say the number could be as high as 15,000. The number is no longer increasing as rapidly and may even have stabilized.

Mr van Straten says Holland and Western Europe have been targetted as a prime market by cocaine traffickers in South America. The US market is saturated, and several countries in South America have been overproducing and are looking to Europe as a new and profitable market.

Peruvian narcotic officials estimated in late 1984 that 30% of cocaine exported was headed to Europe. That percentage may have increased.

The total amount of cocaine coming into Holland is impossible to determine. In 1985, 101 kilograms were seized by the police, down from 180 kg in 1984.

"But, that does not mean the problem is decreasing. Cocaine seized in other countries was found to be destined for Holland, and some of the coke seized here had another final destination," said Mr van Straten.

Amsterdam is renowned as a 'drug paradise' in Western Europe.

Mr van Straten: "We are one of the most interesting countries for traffickers."

Holland's geographic position is partly responsible; it has a long unguarded shoreline, a liberal border with Germany and a free border with Belgium, a major international airport, and the world's busiest port (Rotterdam). Drug traffickers and users were also attracted by liberal drug laws — changed in 1976 — and, Mr van Straten adds, "the tolerant attitude of the Dutch people.

"It's a dangerous problem and difficult for the police. We should have stricter controls at the borders, but they are talking about making the border with Germany free (for economic reasons). So who is going to control Holland's border?

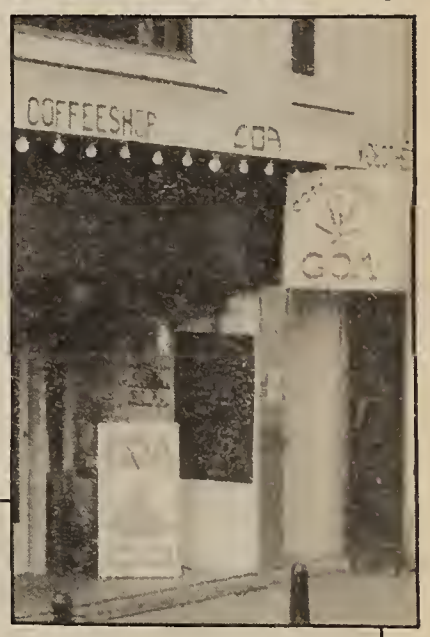
"Holland and Europe will be flooded with cocaine from the South American cocaine-mafia."

Mr van Straten says international cooperation is essential. Besides its role in Interpol, the CRI maintains direct contacts with narcotic bureaus around the world — including the Royal Canadian Mounted Police. Its officers are also posted in the embassies of drug-producing countries.

Mr van Straten and Mr Koek agree education is important.

Mr Koek: "It can be difficult, but they must be forewarned. You can explain the frightening consequences."

He is not convinced the Dutch government is always doing enough, or taking the right steps. "But, they are dealing with it — they accept that there is a problem. In that respect, they are ahead of many European governments."



Centraal Square: the city is renowned as a 'drug paradise.' Shop offers coffee, marijuana (above)

UK singles out kids for new anti-smoke drive

By Alan Massam

LONDON — A slow decline in cigarette smoking among British adults in recent years hasn't been matched in children between 11 and 16 years of age.

And, among certain age groups — notably girls aged from 14 to 15 years — smoking has actually increased.

Parliamentary Secretary for Health Ray Whitney said the statistics are based on a 1984 survey of 9,234 school children in nearly 300 schools.

Mr Whitney announced a new government-backed campaign to discourage teenagers from smoking. It will be run on television and in the cinema and will be piloted for a year in two regions of England, Tyne Tees and the South.

Mr Whitney: "The extent of cigarette smoking among young people is a serious cause for concern to the government. Smoking is a difficult habit to break once it is established. It is therefore vital that we step up efforts to dissuade youngsters from ever taking it up — especially as it is known to be responsible for an enormous amount of ill health, disease, and premature death. No less than 100,000 people are dying each year in the United Kingdom from smoking-related diseases."

Mr Whitney did not comment on the voluntary agreement between the government and tobacco companies allowing tobacco sponsorship of sports events — which have a great deal of appeal to young people.

A spokesman for the British Medical Association (BMA) said the increasing number of British school children smoking is "a black spot in the nation's health." By the age of 16 years, nearly 40% of children smoke, and the number has increased since 1982.

The spokesman added: "Widespread advertising and promotion of cigarettes are behind the increase in children smoking. A recent survey shows that more than 70% of children think cigarettes are advertised on TV, although such advertising was banned in 1965.

"Children are exposed to extensive televised coverage of tobacco-sponsored sports, and studies have shown the brands preferred by children are the ones with the highest advertising expenditure.

"The voluntary agreements first introduced in 1982 between the government and the tobacco industry to control the advertising and promotion of cigarettes are failing to protect children.

"The government's response — to spend an extra £1 million (Cdn $2 million) on specific TV advertising — is not the answer. Cigarette advertising and promotion are pervasive and powerful. Over £110 million are spent on tobacco promotion in all media. The new survey figures confirm that advertisements are drawing new young smokers to an addictive drug which can kill them."

The BMA spokesman said the tobacco industry must bear the responsibility. "The advertisements should be stopped," he said.

British 11 to 16 year olds smoke between £70 million and £90 million worth of cigarettes every year.

Reminds me of when we were kids

Snuff-dipping dangers worry health council

LONDON — The Health Education Council here is making an all-out effort to discourage the spread of so-called "snuff dipping" among British youngsters.

(Snuff dipping is the sucking of a sachet of fine-ground tobacco — a habit which has become common in the United States and Scandinavia in the last few years and now involves between 20% and 30% of school children in some areas of these countries (**The Journal**, March).)

Council chairman Sir Brian Bailey has written directly to newspaper editors urging them to decline advertising for the tobacco sachets, which are being marketed in Britain by US Tobacco International as "Skoal Bandits" (**The Journal**, November, 1985).

Sir Brian says the British government's Committee on Carcinogenicity has found snuff dipping is associated with an increased risk of oral cancer and dental problems. He adds that the department of health and social security has written to all doctors in Britain alerting them to the dangers of the product.

"The press has carried many stories recently about the dangers of smoking tobacco, and I am sure that you would agree that we should safeguard the health of young people," he adds.

INTERNATIONAL

Female smokers: snowballing into the future

A 'staggering' 200% increase for women

Lung cancer deaths soaring

By Thomas Land

GENEVA — Lung cancer mortality in women has increased by 200% in Canada and 27 other industrialized countries, states a 20-year survey published by the United Nations World Health Organization (WHO).

The WHO is seeking a combination of measures, including health education, public information, legislation, and mass media campaigns to confront the global "smoking epidemic."

A WHO spokesman blames the rising death rate on correspondingly increased cigarette consumption by women, "who are still being induced to confuse personal liberation with the smoking habit."

The survey was conducted in Canada, the United States, Britain, France, and elsewhere. Initial analysis published in the WHO's *Weekly Epidemiological Record* observes: "The possibility of preventing tobacco-induced cancers seems not to have been exploited very effectively."

The study shows that, because of smoking, the number of lung cancer deaths in men jumped to 225,000 from 118,000 in the 20-year period. Women fared even worse, says the WHO, "since their deaths from lung cancer went to 66,000 from 22,000, a staggering 200% increase."

The statistics are somewhat qualified by adjustments which take into account the inevitably increasing incidence of cancer in an aging population. Even so, the adjusted increase in lung cancer mortality — which is blamed largely on smoking — was 135% for women, compared with 76% for men.

Families pass smoking to women

By Pat McCarthy

AUCKLAND — Women who smoke appear to be influenced by smokers in their families, especially their partners and mothers, a New Zealand study suggests.

Of 339 women smokers studied, 58% had partners who smoked, compared with only 27% among the 639 non-smokers in the sample. This difference was consistent in all age groups, from 18 to 60 years.

Smokers were also more likely to have a mother who smoked — 31%, compared with 20% for the non-smokers. They were also more likely than non-smokers to have a father who smoked, although this difference was not statistically significant.

"The finding," says Jane Chetwynd, PhD, of the Christchurch Clinical School of Medicine, "gives cause for additional concern at the increasing number of women smokers because of the snowballing effect on future generations. As more women smoke, then more daughters are likely to smoke, and, in turn, more granddaughters are likely to smoke, and so on. The need to break this chain is apparent."

Dr Chetwynd said the higher proportion of smoking partners might be because individuals who smoke are attracted to each other. "But, it may also be that women have greater difficulty in giving up smoking when their partners smoke.

"In either case, it would seem one way to help women stop smoking would be to encourage couples to give up together, and to provide them with appropriate joint therapy and support."

Of the 339 regular smokers in the study, 40% reported smoking 20 or more cigarettes a day. The proportion was higher among younger women.

The non-smokers included 182 (19%) who reported they had at one time smoked.

Besides coming from a lower socio-economic group than non-smokers, smokers in all age groups were more likely to have had marital, sexual, or financial problems in the previous three years and to rate both childhood and adulthood as being unhappy.

Heavy use of tea, coffee, sugar, and alcohol was also more frequent among smokers.

Interviews with the 978 women, none of them in full-time paid employment, were undertaken as part of a larger study of physical and emotional health states. The findings on smoking were reported in the *New Zealand Medical Journal* (1986; 99: 14-77).

STATS·FACTS

Older Canadians: Alcohol and Other Drug Use

***Manuella Adrian**, head, statistical research program, Addiction Research Foundation, based Stats•Facts on:* Statistics on Alcohol and Drug Use in Canada and Other Countries, *Volumes 1 and 2 (based on data available by September, 1984).*

Alcohol

How many older Canadians drink?

A 1983 national Gallup survey indicates that 59% of people aged 50 years and older — or 3.5 million people — have occasion to drink alcoholic beverages. The percentage of users among older people differs slightly from province to province. In Ontario, 73% used alcohol in the last 12 months (1984). Twenty-nine percent of Ontarians aged 50 years and older drink five drinks or more at a single sitting, and 18.5% report becoming "high" or "tight."

However, most abstainers (1.6 million people or 57% of all abstainers) are in this age group.

Those aged 50 years and older are more in favor of raising the legal drinking age, increasing the price of alcoholic beverages, and banning all liquor advertising. They are less in favor of increasing government advertising on the dangers of drink than people in younger age groups.

How many elderly people contravene alcohol-related legislation?

Ontario court data for 1979 indicate 2.3% of all convictions for alcohol-related driving offences — driving-while-impaired, having a blood alcohol level in excess of 0.08%, or refusing a breath sample — are for people 60 years and older.

People aged 50 years and older are more in favor of random breath tests, tougher sentences for drinking and driving, and jailing drivers who have had more than one drink of an alcoholic beverage, than are people in younger age groups.

How many have alcohol-related health problems?

In 1980-81, there were 5,945 cases of those aged 65 years and older treated in general hospitals in Canada for alcohol-related problems. Problems included alcoholic psychoses, alcohol-dependence syndrome, non-dependent abuse of alcohol, toxic effects of alcohol, and chronic liver disease and cirrhosis.

The older make up about one-tenth of Canada's population, but they account for 13.5% of all alcohol problems, almost one-quarter of all cases of chronic liver disease and cirrhosis treated in general hospitals, and more than one-fifth of all cases of alcoholic psychoses treated in psychiatric hospitals.

In 1981-82, 279 cases of alcohol-related problems — alcohol-dependence syndrome and alcoholic psychoses — were treated in psychiatric hospitals in Canada.

A 1982-83 survey of all types of alcohol treatment services in Ontario indicates 2,265 people 65 years and older were treated for alcohol-related problems. This age group accounted for 4.9% of all treatment provided in detoxification centres and in hospital- and community-based residential and non-residential facilities.

How many older Canadians receive disability pensions because of alcohol-related problems?

Statistics for pensions issued in February, 1980 indicate 1,422 Canadians between the ages of 50 and 64 years received a disability pension for alcohol-related conditions.

How many elderly people die of alcohol-related disorders?

In 1982, there were 1,073 deaths from alcohol-related diseases — chronic liver disease and cirrhosis, alcohol-dependence syndrome, alcoholic psychoses, non-dependent abuse of alcohol, and toxic effects of alcohol — in Canada. The older age group accounted for 35% of all alcohol deaths, while making up only 10% of the population.

Tobacco

How many smoke?

A 1983 Canadian Gallup survey indicates one-third of people aged 50 years and older smoke. But, a smaller proportion of this age group smokes than do younger age groups.

How many die of smoking-related health problems?

In 1982, 36,849 Canadians 50 years and older died from smoking-related conditions. As suggested by the comprehensive standards of the (then) United States department of health, education, and welfare, this statistic includes all deaths in the older age group caused by chronic bronchitis, asthma, and emphysema and 30% of deaths in the age group due to neoplasms and to diseases of the circulatory system such as stroke, hypertension, and heart disease (1982).

Other drugs

What psychotropic drug is used most by older Canadians?

Sleeping pills and tranquillizers.

How many use sleeping pills?

A 1984 Ontario survey indicates 13.2% of people aged 50 years and older — or an estimated three-quarters of a million — used sleeping pills at least once in the previous 12 months.

How many use tranquillizers?

The 1984 Ontario survey shows 13.2% of those aged 50 years and older — or an estimated three-quarters of a million people — used tranquillizers at least once in the previous year.

How many use stimulants?

Less than 1% (0.6%) of people aged 50 years and older — or an estimated 35,000 people — used stimulants at least once in the previous 12 months, the 1984 Ontario survey indicates.

How many use cannabis?

The same Ontario survey shows 1.1% of people aged 50 years and older — or an estimated 65,000 — used marijuana at least once in the previous 12 months.

How many use cocaine?

The 1984 Ontario survey reports 0.4% of people aged 50 years and older — an estimated 24,000 people — used cocaine at least once in the previous 12 months.

How many older narcotic drug users are there in Canada?

There were 127 illicit narcotic drug users aged 60 years and older — or 0.01% of all users — in the records of the Bureau of Dangerous Drugs in 1982.

How many older Canadians have drug-related health problems?

In 1980-81, there were 1,167 cases of people aged 65 years and older treated in general hospitals in Canada for drug-related problems — drug psychoses, drug dependence, non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotherapeutics.

In 1981-82, 23 cases in this age group were treated in Canadian psychiatric hospitals. The drug-related problems included: drug psychoses, drug dependence, and non-dependent abuse of drugs.

How many older Canadians receive a disability pension for drug-related problems?

There were five Canadians between 50 and 64 years of age receiving disability pensions for drug-related conditions in February, 1980.

How many die of drug-related disorders?

In 1982 in Canada, 68 older people died from drug-related diseases — non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotherapeutics.

These data are based on administrative reporting systems, or on surveys of the general population. Estimates based on surveys are approximate figures only. The real figures may be slightly smaller or larger.

* * *

Readers requiring Canadian statistics are invited to write to The Journal, 33 Russell St, Toronto, Canada M5S 2S1. Statistics on other target groups will be addressed, from time to time, in forthcoming editions of The Journal.

DEPARTMENTS

New Books

by MARGY CHAN

The Slang and Jargon of Drugs and Drink

. . . by Richard A. Spears

Compiled by a linguistics professor, this volume contains approximately 8,000 entries and 10,000 definitions of terms associated with alcohol and other drug use. The book is well-researched with sources, dates, and origins for these terms. Each entry is indexed to one or more of 258 listed sources.

This dictionary, which traces the history of the words, has a greater appeal to lexicologists and anyone interested in drug sub-cultures than Ernest Abel's two works, *Dictionary of Alcohol Use and Abuse* (Greenwood, 1985) and *A Dictionary of Drug Abuse Terms and Terminology* (Greenwood, 1984).

Scarecrow Press, PO Box 4167, Metuchen, New Jersey 08840, 1986. 601 p. $42.50. ISBN 0-8108-18647.

Drugs and Behavior: An Introduction to Behavioral Pharmacology

. . . by William A. McKim

The first five chapters of the book introduce basic concepts of behavioral pharmacology. The remaining nine chapters are devoted to different drugs or classes of drugs. The individual chapters on drugs begin with a discussion of sources, a brief history, pharmacology, metabolism, physiological effects, and treatments, followed by a list of bibliographical references.

This book will be useful to students in psychology, pharmacology, and medicine, and to general readers with a serious interest in the effects of drugs on behavior.

Prentice Hall, Inc, Englewood Cliffs, New Jersey 07632, 1986. 288 p. ISBN 0-13-220732-X.

Adolescent Drug and Alcohol Abuse Handbook for Parents and Professionals

. . . by Deborah L. Sherouse

The book examines the problem of adolescent alcohol and other drug abuse, its causes and solutions. There are special chapters for parents on family relationships, communications, and related issues. The book, written by an experienced drug abuse counsellor, includes useful features — a glossary of drug terms, resources for information, and referral agencies in the United States.

Charles C. Thomas, 2600 S First Street, Springfield, Illinois 62717, 1985. 229 p. ISBN 0-398-05168-2.

Other books

Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors — Alan G. Marlatt and Judith R. Gordon (eds), 1985. Relapse prevention: theoretical rationale and overview of the model; situational determinants of relapse and skill-training interventions; cognitive factors in the relapse process; cognitive assessment and intervention procedures for relapse prevention; lifestyle modification; alcoholic relapse prevention and intervention: models and methods; the problem drinkers' project: a programmatic application of social-learning-based treatment; preventing relapse in ex-smokers: a self-management approach. The Guilford Press, 200 Park Ave S, New York, NY 10003. 558 p. $39.50. ISBN 0-89862-0090.

Treating the Alcoholic: A Developmental Model of Recovery—Stephanie Brown, 1985. This book is about a new model of treatment that combines Alcoholics Anonymous and psychotherapy. Part 1: model building: part 2: clinical applications: part 3: AA and psychotherapy. Index. Bibliography. John Wiley & Sons, New York. 348p. $49.95. ISBN 0-471-81736-8.

Community Response to Alcohol-Related Problems: Review of an International Study: — E.B. Ritson, 1985. This book reviews the responses of communities to problems brought about by rising global production and consumption of alcoholic beverages in three different settings: Mexico, Scotland, and Zambia. World Health Organization, Geneva, Public Health Paper No 81. 58p. ISBN 92-4-130081-7.

Treatment of Black Alcoholics — Francis Larry Brisbane: Maxine Wombe, (ed), 1985. Focuses on the counselling and treatment needs of black alcoholics, covering policies, programs, and personnel necessary to meet their treatment needs. A monograph also published as the journal *Alcoholism Treatment Quarterly*, Vol 2, No 3/4, Fall/Winter, 1985. Haworth Press, New York. 270p. $22.95. ISBN 0-86656-403-9.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $24 per year
Air Mail: add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Alcoholism and the Elderly

Number: 733.
Subject heading: Drugs and the elderly.
Details: 20 min.
Synopsis: One in four senior citizens has alcohol problems. And, many have problems with over-the-counter and prescription drugs. The signs of dependency in the elderly are the same as with any age group, but are often dismissed as simply a result of aging. Several people from the DePaul Rehabilitation Center discuss the problems and the process of rehabilitation. It is suggested senior citizens dependent on alcohol or other drugs need intensive individual counselling. Limitations because of their age must also be considered. AA (Alcoholics Anonymous) is recommended as being useful for many elderly alcoholics.
General evaluation: Poor to fair (2.7). The film contains good information about alcohol and senior citizens. Unfortunately, the round table discussion format is not interesting. More importantly, the film emphasizes only total abstinence and hospital-based rehabilitation programs. This treatment objective and setting are likely to result in many elderly people being unwilling to seek or accept help.
Recommended use: With a resource person, the film could be used with senior citizen and church groups and in rehabilitation centres.

Never Buy Anything Built on a Monday

Number: 731.
Subject heading: Employee assistance programs.
Details: 20 min.
Synopsis: Russell Smith delivers a lecture on the cost to industry of alcohol and other drug abuse. He outlines the effects of alcohol on the body and behavior changes with each successive drink. Dr Smith says if a person drinks excessively, the withdrawal effects can be similar to an LSD or "speed" trip. A person experiencing such withdrawal is a danger to himself and to co-workers.
General evaluation: Very poor (1.1). This film was judged to be of little educational value because of its lecture format and exaggerated statements.
Recommended use: None.

The Alcoholic: Don't Know Why

Number: 732.
Subject heading: Alcohol/alcoholism: overview.
Details: 58 min.
Synopsis: Sidney Wolfe interviews a recovering alcoholic. They discuss the alcoholic's feelings about alcohol, his drinking experiences, and an automobile accident in which he was involved. He had been a heavy drinker in the army; drinking was a way of life. After other unpleasant consequences, the man obtained professional help and is now trying to restructure his life.
General evaluation: Very poor (1.1). The conversation between two people was judged boring and lengthy.
Recommended use: None.

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Preventing Alcohol and Other Drug Abuse Within Our Society — May 15, Toronto, Ontario. Information: Ontario Council for Leadership in Educational Administration, 252 Bloor St W, Ste 12-115, Toronto, ON M5S 1V5.

Management for Supervisors in the Health Care Setting — May 20-21, July 2-3, Toronto, Ontario; May 22-23, Ottawa, Ontario; May 26-27, Calgary, Alberta. Information: Ingrid Norrish, director, professional and management development, Humber College, Box 1900, Rexdale, ON M9W 5L7.

Youth and Drugs, PRIDE CANADA Conference — May 22-24, Saskatoon, Saskatchewan. Information: Eloise E. Opheim, PRIDE CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Ontario Association of Professional Social Workers Annual General Meeting and Provincial Conference — May 29-31, Waterloo, Ontario. Information: OAPSW, 410 Jarvis St, Toronto, ON M4Y 2G6.

Canadian Mental Health Association Ontario Division 34th Annual Meeting and Conference on Mental Health Futures — May 30-31, Toronto, Ontario. Information: Oscar Johvicas, CMHA/Ontario Division, 56 Wellesley St W, Ste 410, Toronto, ON M5S 2S3.

Drugs, Rock and Roll, and the Work Ethic — June 2, Toronto, Ontario. Information: Cathy Blake, special events, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Group Psychotherapy Today — June 6-7, Toronto, Ontario. Information: Ontario Institute for Studies in Education, conference centre, 252 Bloor St W, Toronto, ON M5S 1V6.

Violence in Contemporary Canadian Society — June 8-11, Ottawa, Ontario. Information: James M. MacLatchie, executive director, John Howard Society of Canada, 55 Parkdale Ave, Ottawa, ON K1Y 1E5.

Ontario Medical Association 106th Annual Meeting — June 9-12, Toronto, Ontario. Information: Annual meeting coordinator, OMA, 250 Bloor St E, Ste 600, Toronto, ON M4W 3P8.

86th Annual Meeting Canadian Lung Association — June 13-16, Winnipeg, Manitoba. Information: A. Les McDonald, director, health education and program services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

77th Annual Conference of the Canadian Public Health Association — Health Promotion Strategies for Action — June 16-19, Vancouver, British Columbia. Information: CPHA, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

Summer School for Addiction Studies — July 7-25, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

27th Annual Institute on Addiction Studies — July 13-18, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

International Conference on the Dynamics of Social Change: Implications for Safety — July 29-Aug 1, Edmonton, Alberta. Information: Conference secretariat, Dynamics of Social Change, 171 Nepean St, Ste 600, Ottawa, Ontario K2P 0B4.

American Hospital Association Annual Meeting — Aug 4-6, Toronto, Ontario. Information: John McMahon, president, 840 N Lakeshore Dr, Chicago, Illinois 60611.

North American Congress on Employee Assistance Programs — Aug 5-8, Toronto, Ontario. Information: Diane Vella, 2154 Crooks Rd, Ste 103, Troy, Michigan 48084.

Canadian Society of Hospital Pharmacists 39th Annual Meeting — Aug 28-30, Ottawa, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

Canadian Society of Forensic Science Annual Conference — Sept 15-19, Niagara Falls, Ontario. Information: Executive secretary, Canadian Society of Forensic Science, 2660 Southvale Cres, Ste 215, Ottawa, ON K1B 4W5.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

Social Science Federation of Canada Research 86: Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario K1A 0N5.

United States

NECAD 86 — May 4-7, Newport, Rhode Island. Information: Jane Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Rd, Newport, RI 02840.

The National Association of Alcoholism Treatment Programs 8th Annual Meeting — May 6-9, Anaheim, California. Information: NAATP, 2082 Michelson Dr, Ste 304, Irvine, CA 92715.

American Psychiatric Association Annual Meeting — May 10-16, Washington, DC. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

7th Annual Conference on Substance Abuse: Chemical Dependency in a Pluralistic Society — May 14-16, Cincinnati, Ohio. Information: Theresa Miller, program director, Central Community Health Board of Hamilton County, Inc, 520-532 Maxwell Ave, Cincinnati, OH 45219.

MDMA (Methylenedioxymethamphetamine): A Multi-disciplinary Conference — May 17-18, Oakland, California. Information: Stephanie Ross, Haight-Ashbury training and education project, 409 Clayton St, Box ED, San Francisco, CA 94117.

5th National Conference on Chemical Dependency — May 21-24, Philadelphia, Pennsylvania. Information: Caron Institute, Box 227, Galen Hall Rd, Wernersville, PA 19565.

A New Role for Mental Health Professionals: Developing Skills as Community Educators — May 31, Oakland, California. Information: Stephanie Ross, training coordinator, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

International Drug Development in the 21st Century — 22nd Annual Meeting, Drug Information Association — June 1-5, Washington, DC. Information: Drug Information Association, PO Box 113, Maple Glen, Pennsylvania 19002.

American Society of Hospital Pharmacists — June 1-5, Denver, Colorado. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

Advanced School of Alcohol and Drug Studies — June 1-6, New Brunswick, New Jersey. Information: Center of Alcohol Studies, Rutgers University, Smithers Hall, Piscataway, NJ 08854.

International Summer School on Chemical Dependency and the Family — June 2-5, Moorhead, Minnesota. Information: James Svobodny, director, Chemical Dependency School, department of social work, Moorhead State University, Moorhead, MN 56560.

3rd Annual Summer Institute for Alcohol and Drug Studies — June 2-6, Evansville, Indiana. Information: Nadine Coudret, director, Institute for Alcohol and Drug Studies, University of Evansville, 1800 Lincoln Ave, Evansville, IN 47714.

Alcohol Impaired Driving: Focus on Prevention — June 5-7, San Diego, California. Information: Alcohol impaired driving conference, University of California, San Diego La Jolla, CA 92093.

The Addictions and the Law —June 7-21, Bothell, Washington. Information: Milam Recovery Centers, Inc, 14500 Juanita Dr NE, Bothell, WA 98011.

Western Conference on Alcoholism and the Family: Bridging the Gap to Family Therapy — June 8-11, Anaheim, California. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

National Rural Institute on Alcohol and Drug Abuse — June 8-12, Eau Claire, Wisconsin. Information: Richard Florence, Arts and Sciences Outreach, 20 Schofield Hall, University of Wisconsin-Eau Claire, Eau Claire, WI 54701.

Sage Conference: Preventing Relapse in Addiction — June 9-11, Adrian, Michigan. Information: Miriam M. Stimson, director, graduate studies, Siena Heights College, 1247 E Siena Heights Dr, Adrian, MI 49221-1796.

Children of Alcoholics — June 13-15, Chicago, Illinois. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Chemical Dependency and Violence Factor: Survivors and Perpetrators of Physical/Sexual Abuse — June 14, Oakland, California. Information: Stephanie Ross, training coordinator, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

American Nurses Association Annual Meeting — June 15-20, Anaheim, California. Information: Judith A. Ryan, executive director, 2420 Pershing Rd, Kansas City, Missouri 64108.

48th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 16-18, Tahoe City, California. Information: Mary Jeanne Kreek, Committee on Problems of Drug Dependence, Inc, The Rockefeller University, 1230 York Ave, New York, NY 10021.

National Clergy Council on Alcoholism and Related Drug Problems Annual Meeting — June 16-20, Chicago, Illinois. Information: John O'Neill, executive director, 3112 7th St NE, Washington, DC 20017.

37th Annual Symposium on Alcoholism — June 16-27, Seattle, Washington. Information: Alcohol studies program, Seattle University, Seattle, WA 98122.

American Medical Association — June 21-25, Chicago, Illinois; Dec 7-10, Las Vegas, Nevada. Information: James A. Sammons, executive vice-president, 535 N Dearborn St, Chicago, IL 60610.

Rutgers Summer School of Alcohol Studies — June 22-July 11, New Brunswick, New Jersey. Information: Center of Alcohol Studies, Rutgers University, Smithers Hall, Piscataway, NJ 08854.

Midwest Regional NACoA Conference on Children of Alcoholics: Young, Adolescent, and Adult — June 28-29, Southfield, Michigan. Information: Midwest Regional National Association of Children of Alcoholics conference, National Council on Alcohol/Michigan, 1405 S Harrison, Ste 308, East Lansing, MI 48823.

17th Annual Narcotic Research Conference — July 6-11, San Francisco, California. Information: E.L. Way, department of pharmacology, University of California, San Francisco, CA 94143.

15th Annual San Diego Summer School of Alcohol and Other Drug Studies — July 6-11, San Diego, California. Information: University of California, San Diego X-001, La Jolla, CA 92093.

Street Drugs: Evolution of Current Trends and Overview of Treatment Models — July 19, Oakland, California. Information: Stephanie Ross, training coordinator, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

New Jersey Summer School of Alcohol and Drug Studies — July 27-August 1, New Brunswick, New Jersey. Information: Center of Alcohol Studies, Rutgers University, Smithers Hall, Piscataway, NJ 08854.

National Prevention Conference — Aug 3-6, Washington, DC. Information: Teddi Pensinger, state and community prevention coordinator, National Institute on Alcohol Abuse and Alcoholism, Rm 16C-10, Parklawn Bldg, 5600 Fishers Ln, Rockville, Maryland 20857.

North American Congress on Alcohol and Drug Problems — Sept 7-11, Boston, Massachusetts. Information: Alcohol and Drug Problems Association, 444 N Capitol St NW, #181, Washington, DC 20001.

Association of Labor-Management Administrators and Consultants on Alcoholism — Nov 1-5, Dallas, Texas. Information: ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Abroad

2nd Annual International Industrial Alcoholism Symposium — May 20-22, Frankfurt, Germany. Information: Annette Stappert, conference coordinator, Conecta, 12 Stooter St, 4330 Mulheim 13, Germany.

32nd International Institute on the Prevention and Treatment of Alcoholism — June 1-6, Budapest, Hungary. Information: International Council on Alcohol and Addictions, case postale 140, CH-1001, Lausanne, Switzerland.

International Symposium on Drinking and Driving: Role of the Alcoholic Beverage Industry — June 4-6, Amalfi, Italy. Information: International Center for Transportation Studies, Viale Bruno Buozzi, 53 00197 Rome, Italy.

3rd Congress of the International Society for Biomedical Research on Alcoholism — June 8-13, Helsinki, Finland. Information: Sari Salo, 3rd ISBRA Congress, Alko Ltd, PO Box 350, SF00101, Helsinki, Finland.

2nd World Congress on Sexually Transmitted Diseases — June 25-28, Paris, France. Information: International Congress Agency, 4, Villa d'Orleans, 75014 Paris, France.

International Symposium on Health Education in Schools — July 6-10, Jerusalem, Israel. Information: D. Tamir, international symposium, PO Box 394, Tel Aviv 61003 Israel.

Psychiatry and its Related Disciplines: the Next 25 Years — Aug 12-22, Copenhagen, Denmark. Information: DIS Congress Service, Linde Allé 48, DK-2720 Vanlose/Copenhagen.

14th International Cancer Congress — Aug 21-27, Budapest, Hungary. Information: Crimson Travel Service, 39 John F. Kennedy St, Cambridge, Massachusetts 02138.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

10th World Conference of Therapeutic Communities — Sept 7-12, Eskilstuna, Sweden. Information: The United Swedish Foundations, Box 354, S-641, 23 Katrineholm, Sweden.

10th International Conference on Alcohol, Drugs, and Traffic Safety — Sept 9-12, Amsterdam, The Netherlands. Information: Symposium secretariat, QLT, convention services, Keizersgraacht 792, NL-1017 EC Amsterdam.

International Symposium on Young Drivers' Alcohol- and Drug-Impairment: Selective Countermeasure Program Development — Sept 13-15, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, department of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

International Conference on Addiction — Oct 19-24, Vienna, Austria. Information: Barbara Turner, conference coordinator, Bldg D, Ste 120, 11050 Crabapple Rd, Roswell, Georgia 30075.

Alcohol Problems in Celtic Countries — Oct 30-Nov 2, St Peter Port, Guernsey, Channel Islands. Information: P.J. Lemmon, Guernsey Council on Alcoholism, 50 The Bordage, St Peter Port, Guernsey, Channel Islands.

National policy: Belize takes the first step

ATLANTA — No nation today — large or small — is immune to the threat of drug use, abuse, and trafficking. And, calls are increasing for more concerted action and leadership in the world community. (See pages M1 to M4 and page 2.)

One of the youngest and smallest nations in the world is Belize, a Caribbean country tucked into an elbow of the Yucatan peninsula, where marijuana is a cash crop and use by the young is high. Belize exemplifies how international assistance can frustrate or help those who want to launch effective programs.

What can be done to help nations in trouble with drugs was described at a recent international meeting here of PRIDE (Parents' Resource Institute for Drug Education) by Arturo Lizano, MD, of Belize. Within the past seven months, with the help of the United States Agency for International Development (AID) and PRIDE, Belize has launched PRIDE-BELIZE-US AID and a number of related programs.

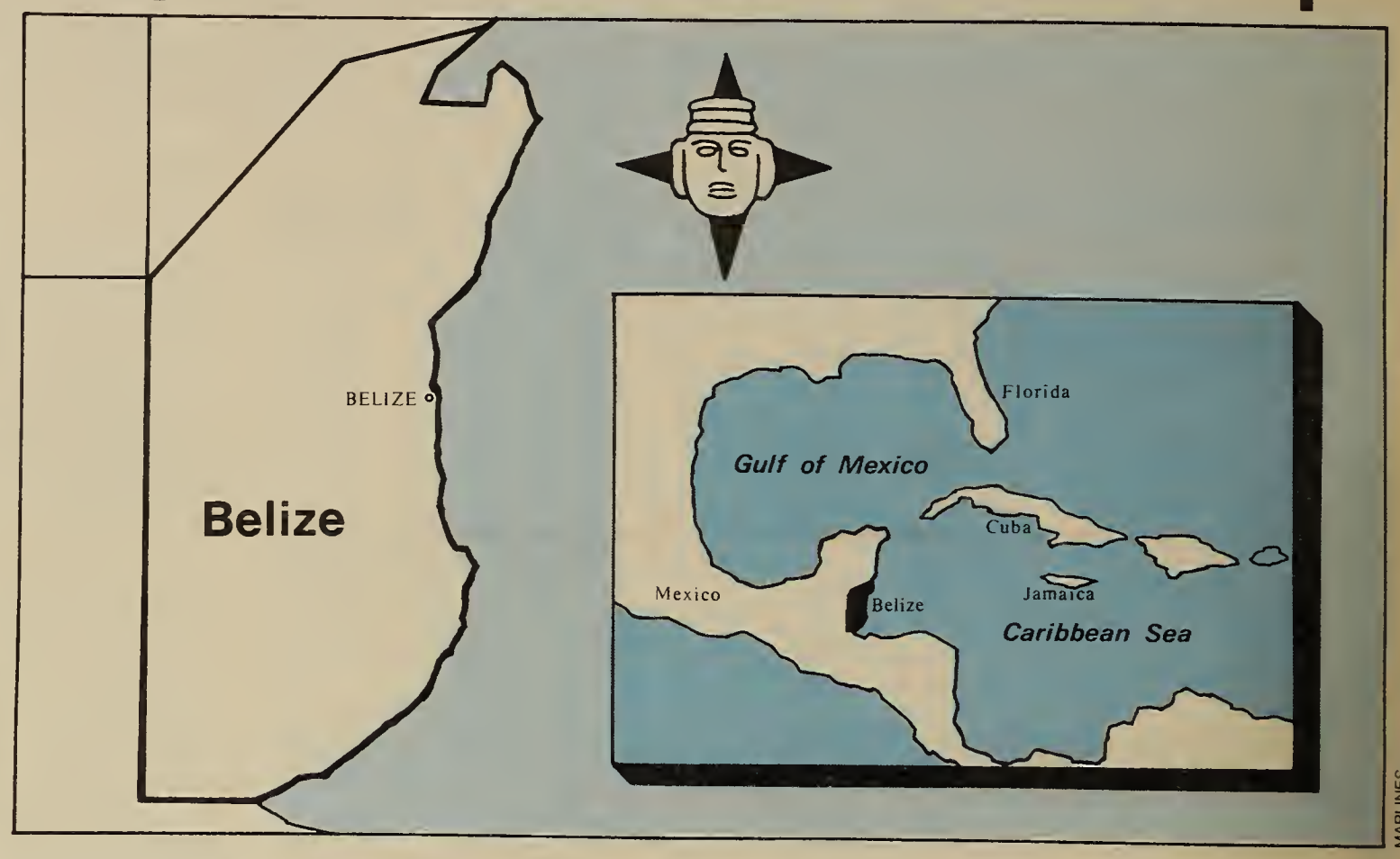
As Dr Lizano points out, the dangers are not limited to Belize.

"Both our youth and the future of our country are being jeopardized by an epidemic. Something has to be done. Many of the developing countries still see drug cash crops as income, in dollars, more than welcome in their economies.

McConnell

"This is not only one country's problem, it is the youth of the world's problem."

Contributing editor Harvey McConnell reports.



Keith (Marsha Manatt) Schuchard, PhD, one of PRIDE's founders, told the conference that when the organization in the United States was founded in a small way in 1978, parents thought drug abuse was only a US problem. "And, we could not foresee it would start to affect children around the world." This year, approximately 60 delegates from abroad attended PRIDE's annual meeting here.

Drugs and drug problems are penetrating more and more into developing countries. "These countries are particularly vulnerable to the movement of money-bearing syndicates and violence as they struggle to build nations, health systems, and school systems. And, the drug culture is moving to these new targets and new markets," Dr Schuchard said.

"What we are seeing is a new kind of imperialism, a new kind of chemical colonialism that renders young people of many different cultures chemically dependent — regardless of political systems in their countries.

"The more open a country is, the more progressive, the more it opens itself up to new ideas, the more vulnerable it will be to drugs. This does not mean it is inevitable, or that the country is necessarily decadent."

It does mean there should be a flow of information, an obligation to make available to parents and children a countermessage to drug traffickers and promoters.

Dr Schuchard says PRIDE has found "very ordinary people living what they think of as small, private lives" are capable of "taking courageous and committed actions.

"They will go to great lengths to protect their own children and those of neighbors and friends and relatives."

* * *

Belize, bordered by Mexico and Guatemala, is the most northern of the Central American republics and the former colony of British Honduras. The country gained independence in September, 1981. The population of some 200,000 is multicultural and multiracial. English is the common language, although Spanish is also spoken by about 30% of Belizeans, and there are a number of Indian languages.

The population is evenly divided between men and women; 63% are under the age of 20 years; and, 55% live in urban areas. Crops include sugar, coffee, citrus fruits, bananas, rice, tobacco, lumber, beef, and seafoods.

Dr Lizano: "But, unfortunately, the production and trafficking of illicit drugs must be added to this list."

Dr Lizano, a psychiatrist who has worked in Central America for 10 years, is director of the PRIDE-BELIZE-US AID project. As a psychiatric consultant to the Belizean government, he helped design a program in drug abuse prevention, education, and treatment for the country.

In 1984, estimates show, Belize harvested 1,159 hectares of marijuana, yielding 1,053 metric tons.

The government has started an eradication program and last year sprayed as much as 75% of the cultivated fields.

"This is very expensive and hard to implement because of the places chosen for farming, normally way out in the jungle — and we are talking about tropical jungle. It is very hard to reach," Dr Lizano told the conference.

But, a recent increase in the number of customs and police officers is starting to make a difference. In recent months, seven tons of marijuana headed for Miami was confiscated, for example.

Lizano: limited economic resources

It is also estimated that local consumption of marijuana is high. The only survey ever done was informal, conducted by a British psychologist in 1983. It showed alcohol to be the preferred drug for those aged 26 to 46 years. But, in the 16- to 25-year-old age group, the main drug of choice was marijuana.

Until the present government took office in 1985, only scattered private groups had been involved in trying to solve Belize's drug problems. Now, the government has strengthened its efforts on drug control, prevention, and eradication.

Dr Lizano recalls that government officials drafted two proposals, on prevention and treatment mainly, for submission to United Nations organizations. The proposals were sent back time and again for further details as more and more information was sought.

Officials in Belize found the effort time-consuming and looked for other ways to proceed.

"We were very lucky to meet the people from the US Agency for International Development (AID). They seemed willing to help," Dr Lizano says.

"We prepared a comprehensive, concise proposal which this time included only one aspect for a program — prevention through education — as a way of helping the country. And, we agreed that the PRIDE approach was the easiest to adopt for our region."

More discussion ensued, and an agreement, which Dr Lizano helped draft, was reached.

Dr Lizano: "I remember calling Atlanta and asking, 'Can you send somebody?' Thomas J. Gleaton, PhD, (executive director of PRIDE), said: 'Yes, sure, when?' And, I said, 'Yesterday.' A representative from PRIDE was in Belize in 24 hours."

Last September, the formal agreement on PRIDE-BELIZE-US AID was signed, with the blessing of the Belize government. PRIDE agreed to administer a substantial grant from AID for Belize.

Dr Lizano says there is one overall goal in the PRIDE-BELIZE-US AID project: "To protect the youth, the future manpower of Belize, while contributing to the political stability of the nation. The purpose is to reduce the prevalence and incidence of drug use and abuse among Belizeans, particularly the youth, by increasing public awareness of the dangers of drugs."

Dr Lizano says the PRIDE - BELIZE - US AID project is currently forming a national drug awareness committee of people who have shown interest and willingness to participate in drug prevention activities.

PRIDE in Atlanta is assisting in establishing the PRIDE-BELIZE-US AID field office to facilitate technical aid and gather materials for the development of the project, as well as providing proper administration.

Dr Lizano says the project will follow the PRIDE philosophy, providing staff to work with and within the community, technical advice, selected speakers and trainers, and experienced group organizers.

He points out that when a developing nation seeks and receives help from an industrialized country, "the possibilities for printed and other types of official information are enormous. And, there are also many other types of resources available."

Media response to PRIDE-BELIZE-US AID has been extremely favorable, Dr Lizano says, with regular articles being published in local newspapers. One of the largest newspapers in the country has started a regular column, asking young readers to send in questions about drugs and related subjects.

Workshops are slated for journalists and television officials.

Dr Lizano: "Accurate messages in the mass media are powerful tools for social communication. I think it is essential that professional messages, which we have adapted to the circumstances in our country, are disseminated."

Efforts are also being made to reach doctors, nurses, police, pharmacists, coaches, and others who can link education and prevention through their responsibilities in Belizean society.

A simple but effective drug use prevalance survey run successfully by PRIDE in the US is being adapted for Belize. The survey can elucidate the specific drug problems in a specific area (**The Journal**, August, 1985).

Another target group for the project is young people not in school and whose parents thus have no contact with the educational system and prevention efforts being made there.

Dr Lizano says one of the most necessary steps is to provide "substitute activities that will help prevent drug use and abuse in developing countries." He suggests youth groups who sponsor activities for youth "to have fun, let us say," are a powerful tool.

One such group is the Belizean version of STOPP (Steps To Offset Peer Pressure), a model used successfully in parts of the US. Six of these groups have been formed in different cities in Belize.

Boxing is an important sport in Belize, and the PRIDE-BELIZE-US AID project is organizing a boxing association to hold tournaments "to get amateurs to practice and come out every Sunday. At the end, we will award trophies."

Overall, Dr Lizano says: "This is the progam we have developed with very limited economic resources but with the help and willingness of an international agency and PRIDE, a grassroots organization without many fancy professionals but with people who are willing to work.

"This is what we're doing in a country which five years ago was a colony and which three years ago had no psychiatrists, no psychologists.

"We see here the hopefulness and the willingness of a country properly channelled the government, the private sector, and international agencies all working together.

"Despite the lack of initial funds, the indifference of some local and international officials — as well as the opposition of others — could not stop us in our efforts because the fact that youth was being destroyed was much more powerful."

THE BACK PAGE

Historical context is critical to good policy

By Joan Hollobon

TORONTO — The potential ramifications of social policy on alcohol should be appraised in an historical context before implementation, says Kaye Middleton Fillmore, PhD.

She says emphasis on efforts directed to the individual drinker may deflect attention away from the broader economic, political, and social factors — such as availability, pricing, taxes — that may have a greater effect in the long run in reducing consumption and alcohol-related problems on a larger scale in both men and women.

Dr Fillmore, a senior scientist in the Alcohol Research Group of the Medical Research Institute of San Francisco, was speaking to a seminar on sex differences and alcohol held by the School for Addiction Studies, Addiction Research Foundation here.

Dr Fillmore said that prior to Prohibition, sanctions against female drinking and drunkenness were great. "Indeed, if ever there was an historical era for women to hide what drinking they did, it was during that period."

Paradoxically, it was during the 13 years — 1920 to 1933 — of Prohibition that women entered the speakeasy and began to drink publicly in increasingly large numbers. During these "dry years," drinking became a mark of sophistication to United States women, and many flouted the law along with the men, she said.

History thus "warns us to steer clear of simple-minded notions . . . ." Surprising backlashes can occur which can aggravate the problem the policy was aimed at.

"It is well to remember that for every well-meaning and well-justified effort to change the status quo, there exist economic and moral interests to challenge it."

As to the wisdom of emphasizing the special needs of subgroups, Dr Fillmore said alcoholism is highest among middle-aged men, and alcohol-related crime, traffic accidents, and anti-social behavior are most prevalent among young men.

"Yet, here we are talking about a subgroup which is not as likely to acquire alcoholism or to exhibit anti-social behavior related to alcohol use in comparison to other subgroups," she said.

This fragmentation "deflects from the conceptual consensus surrounding the problems at hand." It might be advisable, she said, to post a symbolic warning that alcohol policy uniquely designated to one subgroup of the population "may be harmful to the alcoholism movement's health."

Vol. 15 No. 6 2nd Class Mail Reg No. 2776 TORONTO, June 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

H.D. Archibald on international collaboration

The centre section

Broadcasters want looser rules on beer, wine commercials

Advertising proposals stir health concerns

By Betty Lou Lee

HULL, Quebec — The Canadian Association of Broadcasters (CAB) is proposing major changes in alcohol advertising practices with a draft code of ethics submitted to the Canadian Radio-television and Telecommunications Commission (CRTC) here last month.

The broadcasting industry's draft code calls for self-regulation, but it is ultimately the CRTC's decision whether to embrace those recommendations.

If the draft code is accepted, there will no longer be a ban on depiction of actual consumption of beer, wine, or cider (there is no liquor advertising on Canadian electronic media), or on celebrity endorsements.

Instead of pre-clearance by a CRTC committee, clearance would be by the Advertising Standards Council. This council now administers voluntary codes for tobacco advertising and for commercials aimed at children.

Geoffrion, Hull, Mosca, Howe: Ontario, Quebec relax beer ad guidelines

More than 30 agencies, organizations, and individuals prepared submissions for the May meeting here.

At a public CRTC meeting last fall, the vast majority of 300 presentations supported regulation of such advertising, and many wanted even more curbs.

Subsequently, the CRTC said it would "continue to regulate" but move toward a more supervisory approach and that the stations it licenses must take on more responsibility and accountability "for satisfying public concerns."

This stand flies in the face of Canadian Health and Welfare Minister Jake Epp, who wants the CRTC to maintain a strong regulatory role, ban lifestyle advertising, reduce the amount of advertising, and force advertisers to spend part of their budgets on health promotion messages.

Jim Anderson, alcohol and drug program officer with the health promotion directorate of Health and Welfare Canada, said self-regulation "would be putting the proverbial fox among the chickens. . . . We feel the whole thing is going to break down in the crunch of competition."

In its brief, the Addiction Research Foundation said since the broadcasters' association benefits financially from alcohol advertising, "it has an unavoidable conflict of interest in the development or enforcement of a code of ethics specific to the advertising of alcoholic beverages."

(See Celebrity, p2)

Device measures alcohol levels in vapors from skin

TORONTO — The alcoholic looks dubiously at the "wrist watch" soldered around his wrist. If he has a drink, the watch will give him a digital readout of the alcohol content in his blood; it may also make him sick.

He avoids the bar; he'd better not risk it.

By Joan Hollobon

An Addiction Research Foundation (ARF) scientist is reporting in Helsinki this month on research that may well be the first step along the road to such a scenario.

Gwynne Giles, PhD, will present a paper at the 3rd Congress of the International Society for Biomedical Research in Alcoholism on a device able to measure alcohol in the body by "sniffing" the concentration of alcohol vapors rising from sweat on the skin.

Although developed as a "skinalyzer," the device can also sense alcohol in biological fluids, such as blood or blood plasma and urine.

The "wrist watch" idea is speculation: the prototype device is a small box. "We are not in the miniaturization business," said Dr Giles, a chemist in the biomedical research program at ARF.

Theoretically, however, there is nothing to prevent the skinalyzer's ultimately being miniaturized and even being used as a kind of "electronic Antabuse (disulfiram)" to stimulate an adverse reaction when it senses alcohol by, for example, stimulating a nerve to induce nausea.

The skinalyzer is not yet on the market. Although Dr Giles and ARF officials are currently discussing development with a number of firms, they do not know yet what it is likely to cost. The basic, "off-the-shelf" sensors are only $15 or less, but the cost of the circuitry, the digital display, the box, and the manufacturing process cannot yet be estimated.

Dr Giles and associates developed the device in a search for markers of alcohol consumption more reliable than simply asking outpatients or their associates if they had been drinking.

Urine tests are disliked by patients and laboratory staff, and urine is unpleasant to transport. Blood tests are time consuming and expensive.

For measuring alcohol in bodily fluids, the device is cheaper than gas chromatography — the gold standard of blood alcohol analysis — by a factor of about 100 and faster by a factor of 10. "And, it's simpler. My eight-year-old twin

(See Alcohol, p2)

Giles: it's simpler

'Ecstasy' — opinions vary on its use and efficacy

By Harvey McConnell

SAN FRANCISCO — Contradictions abound: some therapists swear by its potential with clients; toxicologists sound caution about possible short- and long-term effects; the United States government fears abuse potential; and, many experienced drug users try it once and forget it.

The diverging views were put by a panoply of scientists at a two-day conference here on a drug which has received drum-

MDMA

rolls of international publicity: 3, 4 methylenedioxymethamphetamine (MDMA), or "ecstasy," or "XTC," or "Adam."

The drug was synthesized in 1914 but remained in neglected obscurity until the early 1980s when some psychiatrists and therapists legally formulated the compound and used it with selected clients. Their glowing reports of increased ability of clients to express emotion, and the positive "attachment behavior" produced hy the "hug drug," created intense media and government attention.

In July, 1985, the US government temporarily placed MDMA in schedule 1 (high abuse potential and no therapeutic use) of the Controlled Substance Act because of fears it might be abused, and because the US is a signatory to the United Nations Convention on Psychotropic Substances, which

(See LSD, p2)

INSIDE

NEWS

Briefly ...

Soldiers' story

GHURBAND, Afghanistan — Soviet soldiers here are using drugs extensively —some of them selling stolen gasoline, ammunition, and guns to support their habits, reports *The New York Times*. Rebel commanders say they've captured Soviets while the soldiers were drugged or trying to buy hashish or heroin from village merchants. Western analysts say the 10,000 Soviet soldiers face the same problems United States soldiers had in Vietnam: they are young, away from home, bored, frightened, and under fierce pressure to prove themselves.

Smokers spurned

LONDON, Ont — Non-smoking job applicants are being given preference over their smoking peers at London University Hospital here. Hospital policy suggests a smoker would be hired only if no nonsmoker with equal qualifications applies for the same job, says *The Toronto Star*. Application forms include the question: "Do you smoke?" together with a statement that the policy is not contrary to any legal statutes.

The absurdity of it all

LONDON — The idea that heroin is Britain's largest drug problem is "absurd nonsense," a delegate told a Royal Society of Health meeting here. Les Kay said it's "miniscule" compared with the legal drug problem, and advertisements give contradictory messages by promoting alcohol and cigarettes beside posters warning against heroin. Although the anti-heroin campaign won't do any harm, said Mr Kay in *Doctor*, too much money is being spent "on something that will have little effect."

Pandas up in smoke

SHANGHAI — Residents here are clamoring for a Peony, while Pekingers want a Big Number Nine. But, everybody would love a Panda — if they could get their hands on one. The Chinese are discovering the lure of brand-name cigarettes, reports *Reuter*, and the brand is a definite status symbol. "Shanghainese people will go hungry rather than be seen smoking the wrong brand," says a Chinese official. Each male resident here is entitled to three brand-name packs a month. Women are not eligible for such rations.

High in the skies

LANSING, Mich — The miniature bottles of liquor most commercial airline carriers sell to passengers for a few dollars cost the airlines only about 28 cents, says *Monday Morning Report*. In the United States, the 13 major airlines take in about $428 million (Cdn $590 million) selling the miniatures; $342 million of that is pure profit. The airlines also ring up sales of about $44 million in beer and another $12 million in wine.

LSD history is revisited in 'ecstasy'

(from page 1)
has MDMA as a schedule 1 drug. Final decision on US scheduling is still under consideration by an administrative law judge.

Legal research ceased, but the publicity generated a boom in street sales. And, MDMA was linked incorrectly in some minds with the highly dangerous "designer drugs."

Speakers here pointed out that MDMA, as a psychedelic drug, is in some ways similar to, but less potent than, LSD and is "going the same way." LSD showed promise as a psychotherapeutic agent, but street use and the resulting adverse reactions led to its ban.

There is no question MDMA causes biochemical, cardiovascular, and neurophysiological changes, although therapists claimed they have seen no long-term effects in clients.

However, a young San Francisco woman recently took MDMA at what was believed to be the therapeutic dose and would have died from toxic reactions but for heroic measures by doctors at San Francisco General Hospital experienced in dealing with drug overdose cases.

Toxicologists point out MDMA can produce all the effects of a stimulant drug. Research in rodents has shown clear neurodegenerative activity and prudence is the watchword until it is known if similar neurotoxicity is produced in humans.

It is also clear that despite the alluring sexual innuendo of the term "ecstasy," even a most preliminary survey among highly motivated people shows its use in sex therapy will be peripheral at best.

To rush in and use MDMA in an attempt to resolve sexual issues is not called for, it was pointed out.

While the concept of using MDMA in sex therapy is appealing to some therapists, little has been done to show that any of the psychoactive drugs, such as LSD and various forms of amphetamines, have had any such beneficial effects.

— next month —

Harvey McConnell reports in full on the conference: MDMA — A multidisciplinary approach

Accuracy similar to breath-test device

Alcohol skin-test prototype promising

(from page 1)
daughters run this thing quite nicely," Dr Giles said.

Other major uses Dr Giles sees for the device are as a laboratory tool, or with unconscious patients.

In pharmacokinetic studies in animals, for example, the device would permit rapid, easy estimations of such things as the distribution, absorption, or excretion of alcohol in the body, without having to draw blood.

In a hospital emergency department, placing the sensor on the skin of an unconscious patient would tell an attending physician whether alcohol was involved.

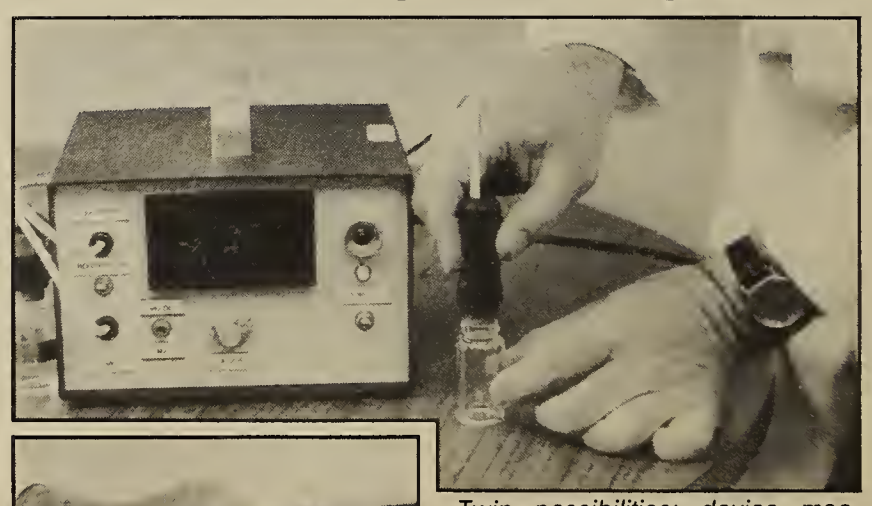
"Legislation allows blood to be taken, and it is always better to take blood — the measurements are more accurate. But, this might be useful for giving 'reasonable and probable grounds' for taking blood," Dr Giles said.

It might even be a useful tool for police, to avoid situations where individuals are jailed as drunks when, in fact, their unconsciousness is due to illness.

(The accuracy of the skinalyzer is about the same as that of a breath-test device.)

Dr Giles said it has been known for a century that alcohol is excreted as vapor through the skin, but measuring it depended on finding the right electronic sensor.

"The first things I thought of to place on the skin were quite unsuitable — one was five feet long. But then, we heard of these sensors and tried them."



Twin possibilities: device measures fluid (above) and vapors (left)

Colleagues associated with Dr Giles in developing the device were senior research assistant Susie Meggiorini and electronic technologist Gary Renaud, who built the prototype.

Comparison with the dipstick, another method of rapid estimation of alcohol in biological liquids, also developed at the ARF, shows pros and cons. (The dipstick, a three-inch cellulose strip with an alcohol dehydrogenase-based reagent pad, turns a pink-red color when dipped in bodily fluids containing alcohol. The stick is then matched against a color-coded scale; the darker the hue the higher the alcohol content.)

As a device for measuring alcohol levels in bodily fluids, the advantages are that the skinalyzer provides a digital display instead of requiring a color interpretation, it can give a quantitative instead of semi-quantitative result, and it is re-usable. Dipsticks cost about 50 cents apiece.

Disadvantages are the higher initial cost of the skinalyzer, the need to dilute the sample if quantitative rather than semi-quantitative analysis is required, and the device is less portable than dipsticks.

The quantity of liquid required is about the same (about a tenth of a millilitre) and the time close (about 30 seconds for the device, about a minute for dipstick).

Thus, if large numbers of samples are being analyzed, the skinalyzer probably would be more economical. But, where a centre carries out only the occasional analysis, dipsticks would be cheaper.

The team is still working to refine the skinalyzer, perhaps with better sensors as these come along, or by building better circuits.

Dr Giles: "Just as with the Breathalyzer, you pretty quickly run up against theoretical limits. In principle, the Breathalyzer is bad because you are converting what's in breath to what is in blood. The breath may indicate an erroneous value for blood simply because you are transposing.

"We are applying the same principle here — converting what's above the skin to what is in the blood. But, it happens that both (the breath-test device and the skinalyzer) work reasonably well."

Celebrity endorsement issue is unresolved

(from page 1)
Pierre Pontbriand, director of information services for the CRTC, said before the May meeting that the CRTC "used to have guidelines, but they were challenged. So, the commission decided the best way was to get the parties together and come up with their own code."

Provincial governments can, and most of them do, have their own regulations for alcohol advertising. The challenge to the CRTC guidelines came from Quebec, where two breweries telecast commercials featuring wrestler Maurice Vachon and former hockey star Bernard Geoffrion.

Recently, the Liquor Licensing Board of Ontario (LLBO) quietly dropped its ban on celebrity endorsements, if they didn't appeal to minors, or suggest the product was involved with the celebrity's success.

The first three such beer commercials in Ontario involve former hockey greats Bobby Hull and Gordie Howe, and former football player, Angelo Mosca.

Jerry Conroy, LLBO manager for advertising, said there would be "shades of grey for some time to come" in deciding which celebrities are acceptable.

"There would be no question about a Wayne Gretzky or a rock star . . . and you won't see Gordie Howe saying he drank Miller Lite while he played for the Detroit Red Wings."

The CAB draft code provides that advertising not associate use of alcohol with the operation of any motorized vehicle, or any activity that requires mental alertness; it not be directed at minors; and, it not imply drinking will improve social acceptance, personal success, or business or athletic achievement.

It has no limitations on frequency of commercials, but they would not be scheduled immediately adjacent to programs intended primarily for minors, such as the Saturday morning cartoons.

It has no requirements for educational messages, believing these should be left to the provinces. But, the CAB notes that broadcasters have provided a substantial number of public service announcements and will continue to do so, "particularly at those times of the year when the possibility of abuse or misuse may be most likely."

— coming up in —

THE JOURNAL

- **A researcher's diary: the private lives of two pioneers**
- **Canadian customs service — stemming the drug flow**
- **Search and seizure: case histories**
- **A week in the life of the Addiction Research Foundation**

NEWS

Court to rule on suit for damages

Inmate challenges X-ray use for drug detection

By Anne Kershaw

KINGSTON — A prisoners' rights lawyer is suing Correctional Service of Canada for $25,000 in damages on behalf of a 27-year-old inmate who was subjected to X-rays of his genitals and rectal area because he was suspected of smuggling drugs into prison.

Authorities at the Joyceville Institution in Kingston agreed to abandon their controversial X-ray program in February, after prison lawyer John Hill initiated legal proceedings. A federal judge is expected to rule on the suit for damages sometime this year.

Officials at the medium-security prison, concerned about the relationship between inmate drug use and violence, launched the X-ray program to deter prisoners from importing pills, particularly diazepam (eg, Valium), in their rectums.

Joyceville: 'there's no question drugs don't belong in a prison environment'

All inmates returning from open visits, which allow physical contact, and from unescorted visits into the community were subjected to the X-rays.

Prison officials maintain those X-rayed had given consent, but Mr Hill said the practice was to detain inmates in a dry cell without a toilet until they had a bowel movement, unless they agreed to be X-rayed.

"There's no question drugs don't belong in a prison environment, but our concern is that X-raying the genital area without proper protection is just going too far," said Mr Hill, director of Queen's University's correctional law project here, an Ontario government-funded clinic providing legal services exclusively to prisoners and parolees.

Mr Hill said prison officials used the institution's dental X-ray machine on "upwards of 20 inmates," without proper shielding, for a period of about a week before halting the practice.

He said he has been instructed by his inmate client to proceed with the suit for punitive damages. "I feel that this is assault and battery on the person of the inmate, and we will be looking for punitive damages."

Mr Hill says while other Canadian prisons have discussed the possibility of using X-rays to detect drug smugglers, Joyceville is the first institution actually to do it.

Correction officials in the Ontario region have been particularly zealous in their efforts to control drug use inside prisons. A 1984 federal government report, known as the Vantour study, concludes violent incidents may be linked to widespread drug use among inmates.

However, the report states most violence could be attributed to tension created by drug trafficking in the prisons, rather than to inmate intoxication.

Canadian prisons using urine tests

KINGSTON — Two Canadian prisons are using compulsory urinalysis testing to detect inmate alcohol and other drug use and to reduce alcohol and other drug-related violence.

The medium-security Joyceville Institution here has used the tests for the past six months. (See story above.) And, a similar program is underway at the Prison for Women here.

For the first four months of the Joyceville program, inmates with positive results received relatively minor penalties such as suspension of privileges. Since March, however, positive results bring internal disciplinary action ranging from loss of privileges, to solitary confinement, to longer prison terms, to denial of parole.

Testing has been carried out only on convicts suspected of being intoxicated or on drugs and can be done for up to 11 drugs — cocaine, heroin, barbiturates, amphetamines, tranquillizers, cannabis, alcohol, opiates, methadone, speed, and phencyclidine.

Prison officials say most inmates favor urinalysis because it means a safer environment.

"The program is proceeding very smoothly," says John Hill, director of Queen's University's correctional law project here.

Negative results can also benefit inmates applying for privileges or parole.

The prison service uses the testing program to identify convicts who might be in need of treatment and counselling. Testing is compulsory, and prisoners refusing to provide samples can be charged with refusing a direct order.

Legal advisers for Correctional Service of Canada maintain testing is legal. However, introduction of a program at Cowansville Prison in Quebec was delayed because of legal challenges by inmates. The issue is still before the courts.

Hill: proceeding smoothly

INSIDE OUT

Singing now, for the silence before

VANCOUVER — Children of alcoholic families need help before they're nine years old. Otherwise, they may learn patterns that will lead them to become alcoholics themselves, says a United States specialist.

*(Claudia Black, PhD, told the 1st Western Conference on Drug and Alcohol Abuse here: "If you're serious about wanting to address alcoholism, you need to be serious about wanting to address children, because they're going to be our future alcoholics." (***The Journal***, May.)*

I did not go to that next meeting of Adult Children of Alcoholics (ACA).

It's not that I had been put off by my first time there. I had been thrilled, and disturbed, and stirred. Hearing those men and women speak so movingly, like a dozen birds who'd been denied their songs for too long and now were singing to the heavens to make up for the silence, touched me.

They, who for so many years had not talked about the sadness, the losses, and the isolation, who had looked upon themselves as victims and too often felt it was their own fault, who held all their fears and confusion inside for decades, were now letting loose.

Each started the song slowly. There were pauses, gropings for the right word and tone, stops to catch the breath and still the emotions before continuing.

But, each was determined to try to get some of it out now, to set the record straight, and to make an accounting before some unknown bar of history. There was an urgency that was like an electric jolt.

I had read a little about ACA. I knew it was a recently formed group that focused on breaking through the denial and shame of being a member of a family that had alcoholism running through its lifestream like a poisonous, time-capsule drug.

The purpose of ACA was to stop the chain of victims raising victims. Another was the notion — so heady I felt giddy when I thought of it — of adopting yourself. What a great motto; what a phrase charged with hope. 'Adopt yourself.' It was so simple, but it encapsulated a struggle for me that had been going on for a long, long time and that I thought I was winning.

I thought that the book on my family and me had been closed

So, I thought I'd go to this meeting, this time, in the guise of a supportive, but nonetheless objective, observer. I'd go to see what was going on, wish them well in my heart, and then get back to living.

Yet, none of what I had read about the organization had prepared me for what I was hearing. And it wasn't the words being said; it was the yearning and the power behind those words.

This is, I thought later, what they mean by an epiphany. These people were testifying. They looked as if they could go on forever.

But, I was scared. I instinctively knew I was not quite ready for it all. It would be difficult for me to participate.

When each had presented, offering himself like a peace-pipe around the table, I realized it was my turn. No, no, not me, I said silently. Ignore me. You don't understand. I'm just here to . . . you know, be a spectator. I have nothing interesting to add.

I looked at the group. I stared down at my plastic coffee cup.

And suddenly, so many things I could say were roaring for attention in my mind. I was feeling too much, getting out of control inside. I was paralyzed. My walls were beginning to break.

I mumbled something about how being kind to each other was paramount. I spoke about the pain I felt around me in the room. That's all I got out. It was all I was going to give them. It was all I could give them. But I knew, they knew how moved I was to be there, to hear them. They weren't going to push. They understood: adopt yourself.

I missed the next meeting . . . . I missed it, not because I was through with ACA, had learned it held little for me, but because the dam had burst.

I had consciously tried to escape my family for so long. I had avoided my mother, put the tattered memory of my alcoholic father to rest, finally, and had forgotten about my sister, my beloved sister, who had killed herself when the demons battered her down, down, down.

I thought it was all over between my family and me. I thought now that I finally seemed to have a somewhat fragile handle on my own drinking disease, that the book had been closed. I had gone to that first meeting hoping for some intellectual understanding perhaps, and here I was, blown away.

The week after the first meeting, all the family ghosts showed up. It was the anniversary of my sister's death; my mother telephoned to say she was coming back to the city where I live, after an absence of almost a decade; and, it was also nearing the anniversary of my finding out how my father ended his days.

I couldn't go to anyone's meeting. I could hardly go to work. It was automatic pilot time. Smile, smile; nod, nod; get through this day.

Why can't this just go away? I asked myself. Do I have to live with these ghosts forever?

I wanted it done with. I was tired of swinging up and down on the seesaw. I was tired of pain. I wanted to be free.

I was torn. But, I was desperate to put the pain behind me. I was also desperate for clarity, for some answers to very old questions, desperate for a connection with other human beings who had been through what I had been through and were trying to make sense of it.

But, going to the meetings meant more pain. I knew that. I thought this is how it goes: you go through pain, you accept it, you live with it, you're 'strong,' you're a man. But, it doesn't really go away.

And then, in order to become whole finally, you learn you have to go through more pain — the pain that comes with trying to understand. Is that what it's all about then, that just as you see your life is almost over you finally gain some wisdom? And, is that price therefore too high? And what will it have all meant, anyway, and will we realize, and will it be enough, when we know the pain has been 'worth it'?

I have now been to my second meeting.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Malnutrition and alcoholic liver disease

Controversy about the role of malnutrition in alcoholic liver disease may have been reawakened. Researchers in a multicentre Veterans Administration cooperative study in the United States have shown a significant relationship between protein-calorie malnutrition (PCM), mortality, and liver disease severity in alcoholics. In the study, 352 patients with alcoholic hepatitis were evaluated for PCM. Eight nutritional parameters were used, following a dietary recall history and repeated interviews on food and alcohol consumption. The most striking finding is the correlation between malnutrition and mortality, researchers say. Of those patients with mild PCM, the mortality rate at one month was 2%, rising to 15% for those with moderate PCM, and to 52% for patients with severe malnutrition. The severity of PCM was also correlated with the severity of hepatic disease: 66% of patients with mild PCM also had mild alcoholic hepatitis; 64% of those with more severe malnutrition had severe alcoholic hepatitis. The relationship between degree of PCM and mortality persisted when the patient's nutritional status was improved in hospital — as patients improved the mortality rate dropped. The researchers conclude, while the study does not establish a cause and effect between PCM and the progression of liver disease, "it strongly suggests an interrelationship."

The American Journal of Clinical Nutrition, February, 1986, v.43:213-218.

A freebasing warning for North America

Evaluation of freebase cocaine abuse in the Bahamas indicates what type of burden North American health care systems could face if similar trends continue to escalate here. The study was initiated by Bahamian physicians and aided by researchers from the department of epidemiology and public health, Yale University School of Medicine, New Haven, Connecticut. Bahamian cocaine abuse trends were investigated after the only psychiatric hospital and the primary outpatient psychiatric clinic there saw an increase in new admissions for cocaine abuse rise to 523 in 1984, from 69 in 1983, and none in 1982. The researchers found admissions for cocaine dependence jumped to 39% of drug abuse patients in 1984, from 9% in 1983. Cocaine freebasing accounted for 98% of cocaine-related referrals to the hospitals in 1984. The change could be traced to a drastic drop in the price of cocaine and to the fact drug pushers switched to selling the type of cocaine used exclusively for freebasing. The researchers said the rise of cocaine-related physical and psychiatric problems in the Bahamas could be related to the interaction of these two factors. The study ends with a warning that if freebasing becomes more popular in North America and more pushers sell this form of cocaine, health care facilities "will need to prepare for an unprecedented influx of drug addicts."

The Lancet, March 1, 1986, v.1:459-462.

Hepatitis patients misdiagnosed

Some alcoholic patients with hepatitis could mistakenly be labelled as having been exposed to acquired immune deficiency syndrome (AIDS) because they react positively to a standard test for the disease. That is the finding of researchers at the Hoxworth Blood Center and Veterans Administration Medical Center in Cincinnati, Ohio. They studied the stored serum of 95 patients with acute alcoholic hepatitis, who were treated in the hospital between 1978 and 1982. The serum samples were tested for antibodies to the human T-cell lymphotropic virus Type III (HTLV-III), considered a marker for exposure to AIDS. Using an HTLV-III enzyme immunoassay, the researchers found 13% of the patients were positive for the HTLV-III antibody. However, using the more specific Western blot test showed all the samples to be negative. The findings were compared to a group of 20 non-alcoholic patients who did not have liver disease, and who had no positive test results. The researchers conclude it is important to realize a high incidence of false-positive results on tests for HTLV-III antibodies may be found for patients with alcoholic liver disease "lest these patients be falsely labelled as having previous infection with the AIDS virus and suffer the socio-economic consequences."

The New England Journal of Medicine, April 3, 1986, v.314:921-922.

Verification of non-smoking benefits

A large, multicentre study has confirmed other epidemiological reports that smoking cessation significantly improves survival in patients with coronary artery disease. The study, using the registry of the Coronary Artery Surgery Study (CASS), was coordinated at the University of Washington, Seattle, Washington. It prospectively evaluated the death rate and morbidity, during a five-year period, in 4,165 smokers with proven coronary artery disease, 2,675 of whom continued to smoke, and 1,490 of whom had quit during the year prior to entry into the registry. The mortality rate for patients continuing to smoke was 22%, as opposed to 15% for those who had stopped smoking. Researchers say the improved survival rate for those who stopped smoking appears almost entirely due to lower rates of myocardial infarction requiring hospitalization or causing death. "Our observations emphasize how important promoting the cessation of smoking is as a positive health measure for patients with coronary artery disease."

The Journal of the American Medical Association, February 28, 1986, v.255:1023-1027.

Pat Rich

Canadian sports amateurs abusing steroids, alcohol

By Betty Lou Lee

TORONTO — Anabolic steroids are the biggest illicit drug problem among Canadian amateur athletes, says a member of the Sports Canada Committee on Drug Abuse in Amateur Sport.

But, alcohol remains the biggest problem among all other drugs, Andrew Pipe, MD, told an international sports medicine seminar here.

The steroids are a particular problem in sports that are less controlled, like weightlifting and body building, he said.

"Many gyms can supply anabolics cheaper than drug stores can."

In some communities, sales of the drugs have increased between 600% and 1,200% in a year, even though legitimate uses for them in medicine, such as for debilitated cancer patients, are rare.

Dr Pipe said one pharmaceutical company had withdrawn its anabolics from the market. Motorcycle gangs have included anabolics in their pharmacopeia. And, he noted, the entire supply of human growth hormone to treat Canadian children who are pituitary dwarfs had been stolen from a hospital in 1984 and diverted to the street trade.

Pipe: athletic Holy Grail

Showing a cartoon of a coach, doctor, and athlete in the poses of the three monkeys who see, hear, and speak no evil, Dr Pipe said that for far too long such people have been saying, 'Everyone else is doing it,' or 'They do it more than we do.'

"This is naive self-deception. We've been doing it just as much as anyone else."

Dr Pipe, who is president of the Ontario branch of the Canadian Association of Sports Medicine and was a member of the Canadian medical team at the 1984 Olympics in Los Angeles, said Canadians became sensitized to the issue of anabolic steroids when some Canadian athletes were disqualified at the Pan American Games in Venezuela.

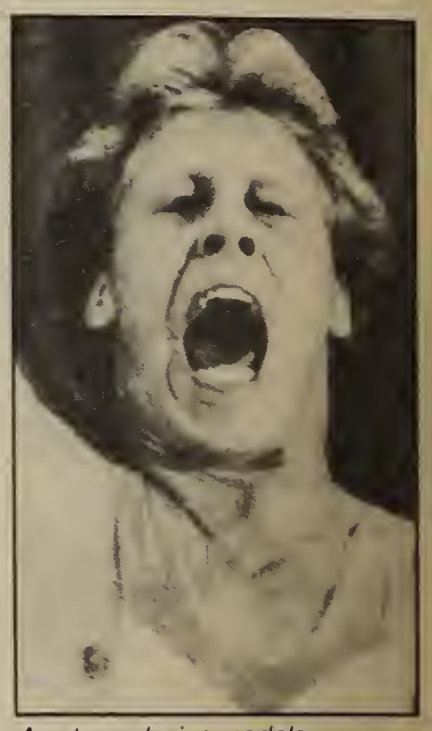
"Drug abuse jeopardizes the integrity of athletes and the sports themselves. The public is becoming jaundiced enough to think mountain climbing is the only sport on the level.

"Taxpayers pay millions for training and transportation for competition, not for steroid biochemists."

The Canadian Ministry of Fitness and Amateur Sport is spending more than $600,000 this year trying to eradicate drug abuse among amateurs.

"Athletes and those working with them can suspend intelligence. . . . They can get so caught up in pursuing an athletic Holy Grail they suspend all judgement," Dr Pipe said.

He said it was "inappropriate for those in power in sports" to be critical of steroids, "while getting support from the tobacco industry."



Amateurs: losing medals

He also lashed out at "sports Svengalis with magic formulas" of everything from steroids to megadoses of vitamins and supplements. Athletes get involved with them because they are "superstitious, vulnerable, faddish, and gullible. They think they can't perform unless they take something on the market, that the answer to their dreams lies in some supplement."

Dr Pipe said it was his impression that cocaine is not a problem in Canadian amateur sports.

"Alcohol is still the major drug of abuse, and it's a problem we tend to gloss over. Especially in hockey, where they go to 'ram back a few with the boys' after a game."

Speaker stresses need to lobby

Politicking vital in addictions field

By Joan Hollobon

TORONTO — Lobby, lobby, lobby. Those are the three key words to achieving change, Kay Stanley, chief of staff to the Canadian cabinet minister responsible for the status of women, told a symposium at the School for Addiction Studies here.

She told 24 social and community workers discussing the sex differences in alcohol use the time is ripe for tackling women's and family problems. Issues such as wife battering are now "in" politically.

"Look at drinking and driving — it is simply no longer acceptable to 'give Charlie one for the road.' "

She said participants in specialist seminars often leave thinking: 'If only that had been done before the regional health council, or officials of the department of health, or the Liberal caucus at Queen's Park, or the floor of the House of Commons.'

"That's the frustration of having expertise and knowledge and knowing decisions affecting you on a day-to-day basis are sometimes made by people on the basis of very limited knowledge."

Ms Stanley, a former president of the national Progressive Conservative women's caucus, joined Walter McLean's staff last July as senior policy adviser on women's issues. Mr McLean is Minister of State (Immigration) and also has responsibility for the status of women.

Ms Stanley became chief of staff in the ministry in October.

She told the seminar it's not necessary to become a card-carrying member of a political party to get a message into the political arena, but participating in a political party has its rewards.

"I cringe when people say, 'Oh, politics, I wouldn't have anything to do with that.' Political decisions are made every day of your life. You negotiate with your kids on what to take for lunch, what clothes they will buy. . . . Those are political decisions," she said.

"I like the quote from Nellie McClung in 1917: 'The country is yours, ladies, politics is simply a public affair — yours and mine and everyone's.' "

Why, therefore, she asked, are women so under-represented in parliament, legislatures, in the upper echelons of the political structure, on hospital boards, and in the health field generally?

Stanley: political decisions

Women have many other responsibilities in their daily lives, she said. But also, "there is still a lot of sexual stereotyping around. It certainly abounds in the halls of parliament, it's in the language of government, and the old boys' network is still very much a reality.

"I think there is still a subtle, and sometimes a blatant, discrimination in the perception of women who have taken leadership roles."

At the same time though, effective lobbying is weakened by power struggles among groups representing such interests as women's health or addiction issues.

"Instead of joining together for a concerted effort, you get internecine battles between agencies in the health disciplines field. A lot of energy is expended trying to keep everybody happy, rather than (their) joining together to create a positive result for all parties," she said.

Her advice: don't disdain letters to the editor, calls to open line shows, or calls directly to politicians. They have impact, particularly when made in quantity.

But, collective action based on well-researched facts and a carefully thought-out strategy is most effective.

"It's the giant step from individual action to a collective, coordinated campaign that's required to give public opinion irresistible strength — better to act collectively than to fume privately," Ms Stanley said.

COMMENT

GILBERT

Notes on the Orient

In March, a sister-city agreement was signed between Toronto and Chongqing — a city in the province of Siehuan in southwest China. I had the good fortune to be part of the delegation that went to Chongqing, via Tokyo and Beijing, to participate in the ceremony. During 19 absorbing days in the Orient, I made notes on the use of popular drugs. Here is what I saw and heard, supplemented by a little research since my return.

General notes

Nicotine is number two — In both China and Japan, caffeine is the most popular drug, as it is in North America, but the second spot is held by nicotine rather than alcohol. Contributing factors may be the high prices of alcoholic beverages, the low prices of cigarettes, and the Oriental Flushing Syndrome (**The Journal**, May, 1980), considered further below.

Most caffeine is taken in the form of tea — Tea appears to be even more pervasive in China and Japan than coffee in North America. Few encounters were without a serving of tea. However, neither country ranks among the first 10 in per capita consumption. In 1982, each resident of Japan used about one kilogram of tea leaf, on average, just a little more than the Canadian figure of 0.9 kg. Chinese consumption was about one third of these amounts. Coffee consumption in Japan is rising rapidly — it rose by 150% during the 1970s — and the beverage is a regular feature of public social activity. Japan now ranks fourth or fifth among importers of coffee, but its per capita consumption remains less than half that of Canada and the United States. We were served good coffee in China, but consumption remains negligible overall.

Male and female habits differ — In both China and Japan, use of cigarettes and alcoholic beverages is mainly a male pursuit. Female use of cigarettes, at least may remain low. In both countries, moves away from the traditional subservient roles of women are coinciding with massive campaigns to reduce cigarette use. Smoking may never become a symbol of female equality.

Oriental Flushing Syndrome — About 50% of Japanese and Chinese react strongly to alcohol. After even small amounts, they show cardiovascular signs of acetaldehyde poisoning, including facial flushing and tachycardia. (Acetaldehyde is an intermediate product of the metabolism of alcohol by the liver.) In Caucasians and non-flushing Orientals, acetaldehyde is immediately broken down by an enzyme in the liver known as aldehyde dehydrogenase, which exists in two forms. The syndrome is associated with absence of the more active form. The effect can be readily induced in Caucasians by administration of disulfiram (eg, Antabuse), which is still used to punish and deter alcohol use.

The taste of tea — In both China and Japan, tea is served plain, without sugar, milk, or cream. The taste of Chinese teas, green or black, is usually familiar. Indeed, until the late 19th century, China supplied almost all of the tea drunk in Europe and North America. Japanese tea, invariably green, can have quite a different taste. One member of our delegation described it as purée of boiled lawn clippings — apparently a result more of the method of preparation than the tea leaf used. The Japanese may beat or grind the leaves to a powder that is swallowed with the liquid beverage after steeping. Even Japanese tea prepared with leaf rather than with powder tastes less 'tea-like' than Chinese tea, possibly because warm rather than boiling water is used. A clear exception to the rule of pleasanter Chinese tea was a foul-tasting brand, bought in Beijing, bearing the message: "This drink has the effects of reducing fat and improving the health of the body and thus giving you a good figure."

Deng Xiaoping and cigarette: official portrait of China's leader in Sichuan gallery

Weaker beer — The listed alcohol concentration of the beers we drank in China and Japan was 3.5%, below even what is known as light beer in Canada, which has 4% alcohol by volume.

There is some concern at high levels about the effects of smoking

Notes on Japan

Tobacco and Salt Museum — Cigarette manufacture in Japan is a monopoly of the state-owned Japan Tobacco and Salt Public Corporation. The corporation runs a museum in Tokyo that was interesting even without a Japanese guide. Three floors are devoted to tobacco and one to salt. Most interesting were the exhibit of tobacco packaging from many countries, the detailed presentation of Japanese cigarette packages from 1893, and the display of cigarette advertising during its early years in Japan. A US company advertised cigarettes in Japan in 1899 with a poster depicting a boy about nine years of age riding his bicycle and enjoying a cigarette. A 1901 poster, produced for a Japanese cigarette company, showed a woman smoking — long before this could be seen in advertising in North America and at a time when feudal attitudes toward women prevailed in Japan.

Everywhere in Tokyo: public ashtrays on adjacent sidewalks, walkways

Public ashtrays — A noticeable feature of outdoor Tokyo is the number and variety of receptacles for cigarette butts. Department stores place them on adjacent sidewalks. Park managers provide them along walkways. Their number reflects the high rate of cigarette consumption and the national preoccupation with cleanliness and appearance.

Cigarette **consumption in Japan** — Japan ranks first among countries in per capita consumption of cigarettes. At about 2,700 cigarettes per person per year, Japan's consumption is now higher than the previous leaders, the US and Canada, both of which have an annual consumption of about 2,500 cigarettes per person. Cigarette use differs markedly between the sexes. About 70% of men are regular smokers, but only about 15% of women. Both proportions are declining, but overall cigarette consumption remains high because smokers are smoking more.

***Karaoke* Bars** — Eight of our delegation went out for a beer one evening in Tokyo and found ourselves with a bill for $144 (Cdn). Total consumption by the group was six beers, one soft drink, two glasses of water, and a single plate of chicken paella. Our karaoke (pronounced "carlaokay" and meaning without orchestra) was, we learned, typical of a popular but expensive form of evening establishment throughout Japan. The essence of karaoke is self-entertainment. Customers take turns to croon favorite ballads. The surroundings are sumptuous with service to match from sophisticated hostesses trained to entertain the usually male clientele with fine conversation. Karaoke is the resort of Japanese middle managers. Westerners normally gain entrance only as guests of regular customers. We wandered in on a slow evening.

Notes on China

Spitting — There is little evident concern in China about the effects of second-hand smoke. Indeed, at the street level, authorities are just getting around to dealing with public spitting, whose eradication in North America some decades ago has been compared with present campaigns to restrict public smoking. Spitters in Beijing may now be fined on the spot and have their names published in the *Beijing Daily*. One report gave the names of 15 cyclists and accused them of "leaving behind vile traces." Last year, spit inspection squads were sent out into the streets with authority to fine spitters on the spot and require them to view their spittle though portable microscopes. A restaurant owner defended public spitting: "It is healthy," he said. "It gets rid of bacteria." Public smoking, now prevalent in China, could disappear quickly if this kind of determination were applied to its eradication.

Concern about smoking — There is some concern at high levels about the effects of smoking. The Ministry of Public Health, working with the Central Patriotic Health Campaign Committee, wants to ban or restrict public smoking, halve the present high-tar level of cigarettes, and require packets to contain a warning message. (Of the many cigarette packets I inspected, just one — at my plate during dinner with the Mayor of Beijing — contained a message: "Cigarette smoking is dangerous to your health.") The last nationwide campaign was in 1979. Since then, the number of smokers in China has risen to 330 million from 200 million. During the same period, per capita consumption increased to 1,100 cigarettes from about 700 a year. The main cause of these extraordinary rises was increased affluence, particularly in rural areas. Tobacco products may not be advertised in China.

Sex differences — About 50% of adult males in China smoke, but less than 5% of women. Such is the expectation that women do not smoke, recent rationing of certain brands of cigarettes in Shanghai allowed male residents of the city three packs a month and female residents none.

Brand confusion — There are about 3,000 brands of cigarettes in China, produced by 146 factories. The China National Tobacco Corporation is trying to reduce the number and establish some as national brands. The concern is to improve the quality of Chinese cigarettes, which, at the bottom end of the scale, can be very rough. The ongoing fads for certain brands in Beijing and Shanghai are probably the result of the corporation's work. (See page 2.) Price differentials among brands are considerable, ranging from about 25 cents (Cdn) per pack to five times as much. Pack-a-day smokers in China spend typically a third of their disposable incomes on the habit. In Canada, the usual proportion for this kind of smoking is about one-tenth.

Alcohol use — Notwithstanding the reported prevalence of the Oriental Flushing Syndrome, our hosts rarely abstained from alcohol at social functions. They rarely showed signs of extreme reaction to alcohol. We were usually served beer, wine, and the potent *mao tai*. Some Chinese drinking practices suggest a boisterous enthusiasm for alcohol. The accepted method of consuming mao tai is to drink the toast in one gulp and then hold the upturned glass over your head. Perhaps syndrome-sufferers are kept away from social functions for 'foreign friends.'

Tobacco ad wars — We returned to Toronto from Hong Kong, the epitome of capitalism, due to be absorbed by China in 1997. Topical there was a proposal to ban tobacco advertising on television. Local cigarette manufacturers, including some owned by the Beijing government, had responded with a campaign with the theme: "As we approach 1997, it is more important than ever to preserve our freedoms." The campaign was promptly banned by the colonial government as being subversive. Advertisements for Winston and Marlboro cigarettes are one of the few public signs of North American influence in Hong Kong. Other advertising is mostly Japanese.

By Richard Gilbert

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Cancer stats aren't enough to deter smokers

What's more astonishing than the figures quoted in **The Journal** (May) on soaring lung cancer deaths is the fact such alarming data fail to make smokers quit — something I deduce from the smoke I find myself required to breathe whenever I enter a public place.

As one who recently sat by the bed of a relative dying slowly from lung cancer, I feel qualified to theorize that the evidence in your story fails to communicate with smokers. Alone, numbers do a miserable job of conveying images of what it's really like to die from the disease.

Might I suggest then that in future you present data within a meaningful context, in terms that convey images?

Don't leave us with numbers about lung cancer deaths in men rising during the past 20 years to 225,000 from 118,000. Tell us instead that the number of people who drown in a sea of mucous manufactured by their infected lungs now stands at a quarter of a million souls yearly.

That's exactly what happened to the person I lost, except it was worse. I'll spare you details of the sideshow that went with it, except to recall the coughing up of spit, perspiration-soaked bedsheets, his emaciation and weakness and confinement to bed, and the laughter of children playing games, happy, carefree, outside the bedroom window.

Above all, I'll spare you the frightened look in his eyes; the panic I felt, able to touch but not rescue a drowning man; the living nightmare it is to sit beside someone slipping beneath the undertow; the nervous smalltalk around the problem; the cruelty of the question, "How are you today?"

Don't give us printouts on deaths of women rising to 66,000 in the last two decades. Tell us instead of the 66,000 women who pitifully suffocate in front of their families each year. Tell us of the 66,000 women annually who know what it is to feel themselves slip away from the ones they love, gasping for precious breath with growing difficulty. Tell us of their desperate fight for time, of their exhaustion but inability to sleep.

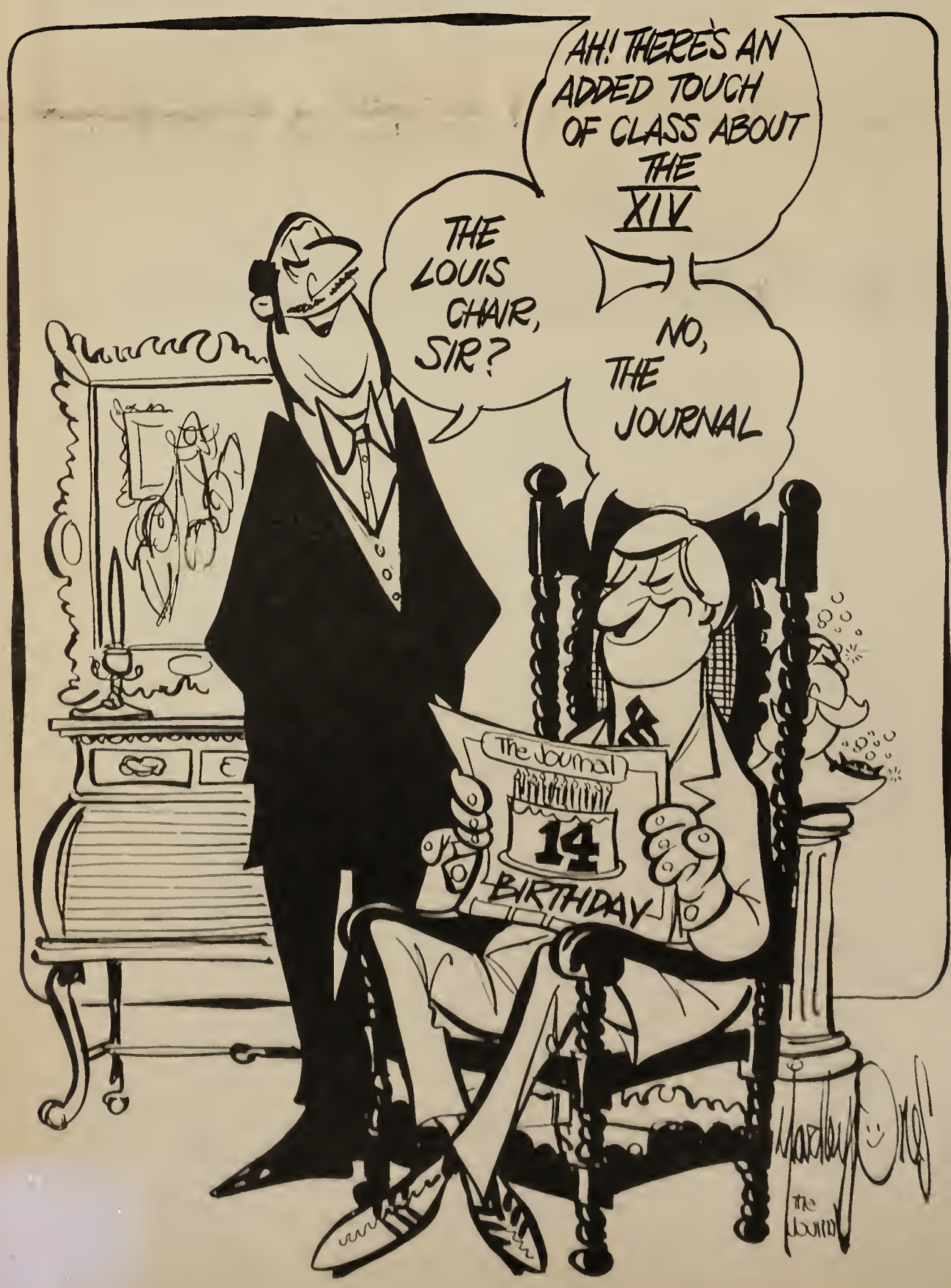
Give us images of them the way they are — bargaining with God, begging that what's happening isn't true. Show us what it's like for them, searching for the strength to tell Bobbie to be a big boy, little Karen not to cry, to let Alan or Peter or Bill somehow know he's been a wonderful husband.

Tell us of their yearning for time to touch and feel, to smell lilacs in springtime, to feel 10 years old again, to walk again by the sea. But above all, describe to us their desire to be at peace when all they feel is hurt, and anger, and panic.

Tell us things that make us want to live, to avoid the agony that goes with the numbers you report about this thing called lung cancer. We might not like reading about it, but it's better than learning about it first hand.

Make your numbers live, and us with them.

Tom Muskett
Toronto, Ontario



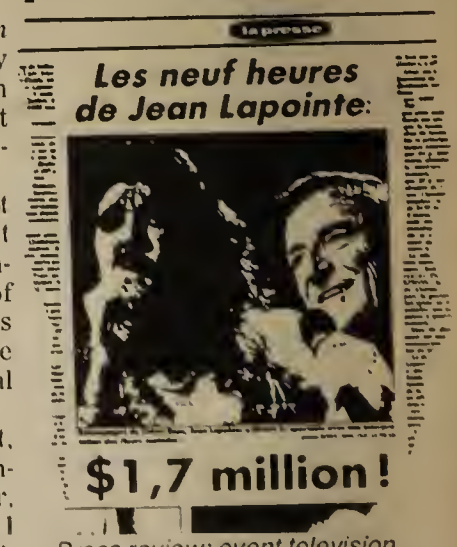
Quebec alcohol telethon surpasses expectations

The people at *la Foundation Jean Lapointe* in Montreal were happy to see the telethon for alcoholism mentioned in **The Journal**. But, not as happy as we were the day following the actual event.

We surpassed our objective not only with respect to money, but also with respect to our educational goals. The great majority of phone calls, letters, and meetings were positive, paving the way, we hope, for the second provincial telethon in 1987.

I should add that Harold Kalant, MD, Ron Hall, Dave Britnell, Henry Schankula, and Peter Loranger, PhD, were all of great help when I visited the Addiction Research Foundation (ARF) in Toronto in January. Manuella Adrian helped us secure the very latest statistics in Canada.

Jean Lapointe therefore mentioned ARF's contribution during the telethon and ARF's name appeared in the credit titles.


la presse
Les neuf heures de Jean Lapointe:
$1,7 million!

Press review: event television

We hope this event, unique in Canada, will receive continued coverage in **The Journal**. We think our telethon is but the beginning.

Incidently, our own Quebec Liquor Board — *La Societe des Alcools* — gave the telethon $100,000, thus showing the new administration's intent to use some of the alcohol revenues to educate the public.

Jacques Perras
La Maison Jean Lapointe Inc,
Montreal, Quebec

Overeaters overview

I read about an Ottawa-based Overeaters Anonymous group in **The Journal** (November, 1985).

I would like to obtain the address of the group because I am working with overweight people and am always looking for methods which give good results.

I would like to congratulate you for your very interesting and informative newspaper.

Nguyen T.M. Nguyet
Clté de la Santé de Laval
Départment de Santé
Communautaire
Laval, Québec

Patrons tip hats

We were informed residents of Ontario could obtain free copies of **The Journal**.

It has proven to be very useful to library patrons at the high school level for information and essays. So, we are requesting a subscription to your excellent newspaper.

Armelle Kingsbury
Bonfield Public Library
Bonfield, Ontario

FROM: The Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse

Heather Graham

Drug control specialists around the world have grappled, for decades, with the problem of curtailing misuse of and traffic in drugs.

While there is no illusion that administrative measures by themselves will be sufficient, the need for mutual assistance and collaboration, nationally and internationally, has never been greater.

H. David Archibald, president of the International Council on Alcohol and Addictions, says the opportunities for collaboration are many. What is needed, however, is the political and bureaucratic will to ensure this happens.

Following is the condensed text of Mr Archibald's paper NARCOTIC AND PSYCHOTROPIC DRUG PROBLEMS: INTERNATIONAL COLLABORATION ON HEALTH ASPECTS, commissioned for the Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse, which was held in London in March. Mr Archibald's paper is the second of two published by The Journal for its readers. Bror Rexed's paper, *The Making of a National Drug Abuse Control Policy,* was published in May.

Archibald

Societies in all parts of the world have discovered substances that suppress pain and sorrow and also provide pleasurable sensations.

The oldest of these plants are the cannabis plant, the opium poppy, and the coca bush leaf. Archeological evidence indicates the growth of cannabis dates back to 6000 BC; religious and mystical use of cannabis in the Indian subculture was reported from about the 7th century AD.

By the end of the 19th century, drug abuse and addiction were seen in many countries and were beginning to receive attention of national governments moving toward social responsibility.

Recognition of the need for international collaboration to suppress drug abuse began during the 19th century with pressure to act coming particularly from missionaries and diplomats.

In 1906, the Chinese government prohibited cultivation of the opium poppy. In 1908, as a result of public opinion and political pressure at home, Great Britain agreed to a reduction in the India/China opium trade, on condition that China reduced domestic production and imports from other countries. That same year, the United States government responded to pressure from an Episcopalian missionary bishop to the Philippines, the Reverend Charles Brent, a Canadian-American, and prohibited the use of opium there for other than medical purposes.

These developments, however, were more symbolic than effective. Recognition of this fact, together with the ineffectiveness of some national efforts to control increasing opiate use in Europe, led a number of governments, in response to an initiative from US President Theodore Roosevelt — again stimulated by the then Bishop Brent — to convene an International Opium Commission in Shanghai in 1909. Representatives of 14 governments participating in the meeting concluded that abuse of narcotics was an international social problem, that its solution was beyond the capacity of single governments, and that, consequently, effective international cooperation was required.

Thus, the foundations for subsequent international efforts to stem the spread of drug abuse were laid.

Three years later, the first International Opium Conference met at The Hague and in adopting the International Opium Convention of 1912, as incorporated later in the Treaty of Versailles, transformed the findings and resolutions of the Shanghai meeting into legal obligations under International Treaty Law.

By 1961, the essence of the provisions in the ensuing series of Conventions and Protocols, developed under the aegis of the League of Nations and the United Nations, was brought together and consolidated in one legal instrument: The Single Convention on Narcotic Drugs, which among all parties to it (115 by January, 1985) replaced all earlier treaties.

The Convention on Psychotropic Substances (1971) is the second, major, contemporary international treaty for drug control. This Convention was created because of the serious consequences to public health caused by the rapid development and widening abuse in the 1960s and 1970s of the newer chemical substances: hallucinogens, stimulants, depressants, and some tranquillizers, which had not been subjected to international control under the Single Convention.

As in the Single Convention, many of the provisions of the Psychotropic Convention restrict use of scheduled or listed drugs for scientific and medical puposes, as well as restricting manufacture, export, import, distribution, and trade in such substances.

Prior to the Single Convention and the Psychotropic Convention, the hope, indeed perhaps the expectation, was that effective law enforcement would reduce the supply of drugs and thus, eventually, "solve the problem." It became eminently clear this had not happened, and measures to reduce demand had to be initiated.

Recognition of this fact led the drafters of the Single Convention to the amending protocol of 1972, which called on member countries to develop health-related programs, specifically for treatment, rehabilitation, and social reintegration of drug-dependent people, as well as education programs for prevention.

Continued on page A2

Narcotic and Psychotropic Drug Problems: International Collaboration on Health Aspects

Thus, countries ratifying the amendment to the Single Convention are committed to the development of programs to reduce demand for drugs.

International bodies

Many regional and international organizations are now concerned one way or another with matters related to drugs. Some devote their attention full-time to drug issues, although most of these deal essentially with enforcement. Others have developed a drug program as a relatively small part of a much larger full-time or part-time function (eg, the International Labour Organization). Still others have an interest in drugs peripheral to their main interests and functions.

However, very few are concerned solely, or even significantly, with drug-related health and social problems.

Below are brief descriptions of some of the major organizations.

The United Nations, through the Economic and Social Council (ECOSOC), is responsible for formulating UN policies, coordinating drug control activities, supervising the implementation of international Conventions, and making relevant recommendations to governments.

The Commission on Narcotic Drugs (CND), a commission of ECOSOC, is the main policy-making body for international drug control. It is composed of 40 members elected from UN member countries who are parties to the Single Convention.

The major purposes of the CND are to assist ECOSOC in supervising the application of the international drug conventions and agreements; to advise ECOSOC on all matters pertaining to control of narcotic drugs and psychotropic substances and, where necessary, to prepare or draft international treaties; and, to consider what changes may be required in the existing machinery for international control of narcotic drugs and psychotropic substances and, when appropriate, to submit proposals and recommendations to ECOSOC.

The Division of Narcotic Drugs (DND) provides secretariat services to the CND and serves as the central repository for UN expertise in the area of drug control. It prepares reports on matters related to international drug control for the CND, ECOSOC, the UN secretary-general, and the General Assembly. It also provides direct assistance to governments.

The International Narcotics Control Board (INCB) is a specialized, non-political UN organization trusted particularly with supervising the legitimate supply of controlled drugs needed for medical and scientific purposes. It consists of representatives of 13 countries elected for their technical competence and impartiality by ECOSOC. Members serve in a personal capacity rather than as country representatives because of a quasi-judicial role assigned to the INCB by the treaties.

The main responsibilities of the INCB under the treaties are to endeavor to limit cultivation, production, manufacture, and utilization of narcotic drugs to the amounts necessary for medical and scientific purposes, to ensure the quantities of these substances necessary for legitimate purposes are available, and to control illicit cultivation, production, manufacture, or trafficking and use of these substances.

The World Health Organization (WHO), a specialized UN agency, is responsible for all aspects of public health. This includes the impact on health of alcohol and other drug dependence and coordination of international and intergovernmental work.

The WHO is one of the most decentralized agencies in the system, with five regional offices throughout the world and with country offices in a large number of developing countries.

Although the WHO has a lengthy list of priorities in the drug field, its expert committee on drug dependence, whose composition of experts varies from year to year, shoulders the main burden of obligation under the international drug treaties. The committee meets in Geneva, usually once a year, to consider the balance between usefulness in health care and potential for health damage of various drugs and then to advise, as necessary, the CND on appropriate action.

The WHO's priorities in the drug field, together with official responsibilities under the international treaties, would imply a staff of reasonable size. Unfortunately, the drug dependence unit in headquarters comprises only two senior staff, with limited support staff. It would appear, therefore, the problem of drug dependence has a rather small claim on the total resources of the WHO, despite numerous resolutions and declarations of support for this work by the World Health Assembly.

The UN Fund for Drug Abuse Control (UNFDAC) was established by the UN General Assembly and ECOSOC in 1971 in recognition of the need for a stronger system of financial support for international drug control. The UNFDAC is supported by voluntary contributions from both government and non-government sources and, in turn, uses these funds to support projects designed to limit the supply of drugs, provide treatment and rehabilitation services, develop educational programs, and support operational research on matters related to both national and international drug control.

The UN Food and Agriculture Organization (FAO) provides advice and assistance relating to crop substitution and community development programs being developed in areas producing opium and coca leaf.

The International Labour Organization (ILO) is active in the field of vocational rehabilitation and training of drug-dependent people. The ILO takes special interest in examining the impact of alcohol and other drugs on the labor force and promoting intervention programs.

The UN Educational, Scientific and Cultural Organization (UNESCO) has a relatively small program in the drug field, concerned primarily with social and cultural aspects of drug abuse and prevention, especially in regard to drug information and education. It sponsors training seminars in various regions, provides travelling fellowships, and has published a number of educational pamphlets.

The International Criminal Police Organization (Interpol) combats drug trafficking by promoting cooperation among law enforcement services of various countries. However, the organization also analyzes and distributes information and intelligence on international drug traffickers, routes taken, and methods used, and provides an early warning system of major shifts in the system. The activities of the drug subdivision are reported to account for more than one-third of the total work of the Interpol general secretariat.

The International Council on Alcohol and Addictions (ICAA) is the oldest and perhaps most widely representative international organization in the field of drug dependence. It is an independent, non-governmental organization (NGO), founded in Stockholm in 1907 and with headquarters now in Lausanne, Switzerland.

The ICAA sees its main purpose as fostering international contact, cooperation, and information transfer among people engaged in the fields of alcohol and other drug dependence. It holds regular meetings around the world, involving policy makers, scientists, social workers, health administrators, teachers, law enforcement officers, and recovered alcoholics and drug addicts from more than 130 member organizations located in every part of the world.

It has developed a special capacity for training programs in developing countries, especially in Africa. It has consultative status with ECOSOC and participates regularly in the meetings of the CND. Since 1968, the ICAA has also been officially associated with the WHO and actively cooperates with that body.

The ICAA assumes a position of neutrality rather than advocacy.

The International Commission for the Prevention of Alcoholism (ICPA), with headquarters in Washington, DC, is an outgrowth of the Seventh Day Adventist Church. Its major objective is to strengthen programs for the prevention of alcoholism and other drug problems through promotion of total abstinence. It has members from a number of countries throughout the world, but the core members in each country are drawn from the Seventh Day Adventist faith.

Regional groups

The Colombo Plan is an intergovernmental organization of 26 countries dedicated to cooperative effort for the socio-economic development of member countries in Asia and the Pacific region. Members include six developed countries (Australia, Canada, Japan, New Zealand, the United Kingdom, and the US) and 20 developing countries (Afghanistan, Bangladesh, Bhutan, Burma, Fiji, India, Indonesia, Iran, Kampuchea [Cambodia], Korea, Laos, Malaysia, the Maldives, Nepal, Pakistan, Papua-New Guinea, the Philippines, Singapore, Sri Lanka, and Thailand).

The drug advisory program of the Colombo Plan, started in 1973, has as one of its major functions the promotion of information exchange through regional conferences and the provision of fellowships for intervention programs within the region.

Within the mandate of the **Council of Europe**, different directorates have programs with concerns related to the use and misuse of drugs. These directorates include human rights, legal rights, social and economic affairs, and the mass media. Coordination of these activities is the responsibility of the Pompidou Group.

The International Federation of Non-Governmental Organizations (Asia) is a regional organization dedicated to establishing a close, working relationship between national NGOs. A major activity is an annual conference for information exchange. The members act as an advocacy group in formulating recommendations directed to governments and institutions in the region.

Some positives

• National collaboration

Although there is usually general agreement nationally and internationally on the need for effective coordination mechanisms at the national level, many countries have difficulties in establishing such mechanisms. Ministries and departments of government often have strong traditions of independence and territoriality and are frequently disinclined to share power, or even information, with other departments.

However, a number of countries with serious drug problems have established centralized national agencies to coordinate activities in the drug abuse field and to be responsible for the development of control and prevention programs. In individual countries, these agencies have produced good results and have also been instrumental in international collaborative efforts.

In Hong Kong, for example, following a number of ineffective actions caused by territorialism among government departments, the government decided on corrective action through an Action Committee Against Narcotics. This body was established as the sole source of advice to the government on all aspects of narcotic problems and consisted of heads of relevant government departments, custom services, prisons, treatment and rehabilitation programs, and public education. An overall strategy was then developed comprising four main elements: law enforcement; treatment and rehabilitation; prevention, education and publicity; and, international collaboration.

• Transfer of technology

With financial assistance from the Canadian government and the UNFDAC, the ICAA is working on a project to evaluate various demand-reduction and prevention programs in a number of countries, in an effort to identify the most effective or potentially effective programs. An international working party has been assembled and, for the past two years, has been gathering background data. A report, to be available soon, will include broadly applicable suggestions for positively evaluated demand-reduction projects for the consideration of concerned international, regional, and national bodies.

For a number of years, opium poppy crops provided a bare income for many villagers in north Thailand. Opium was also the only medicine available to help villagers manage physical and psychic problems associated with living under primitive conditions.

A joint community development and crop substitution program — a collaborative effort of the UNFDAC, the DND, the WHO, the ILO, and the government of Thailand — experimented with crops that could be substituted for opium and would, at the same time, ensure continued financial security for the villagers. Basic health care services were provided as well as education to reduce illiteracy.

The project appeared to offer the best hope for reducing the supply of opium and its impact on the people in the region, although it is too early to judge the long range outcome. However, it has been demonstrated that cash crops other than opium can be grown in remote jungle areas to financial advantage and that a basic health service can be developed which results in an overall improvement of health. Moreover, the program can be replicated from village to village with little external assistance.

The possibility of transferring this kind of program from Thai tribal villages to South American coca bush producing areas provides an example of the broader potential for the transfer of technology and experiences from one developing region to another.

• Training

Under WHO auspices, a consultant from the WHO Collaborating Centre in Canada, the Addiction Research Foundation (ARF), visited Bangkok to review the potential for development of a comprehensive treatment and rehabilitation program. There were a number of outpatient methadone clinics, but it was deemed advisable to develop a wider range of treatment and rehabilitation models. Selected professionals from Thailand were sent to the ARF for intensive training.

This illustrates the value of a relatively low-cost program for the transfer of experience from one country and its adaptation and application to another. Similarly, WHO travelling seminars have been organized in cooperation with national governments in a number of countries, including the Union of Soviet Socialist Republics.

The ICAA has developed a useful training model in West Africa. The objective is to train trainers so that the country can be-

come self-sufficient. Originally, the project was established in Nigeria for health and social service personnel only. It became clear, however, that law enforcement officers, in particular custom officers, were in urgent need of training not only in detecting illicit trafficking, but also in understanding the need for and strategies involved in programs to reduce demand.

The Customs Cooperation Council (CCC) provided faculty members. The 1985 training course included not only medical officers, psychologists, nurses, medical-social workers, but also police and custom officers.

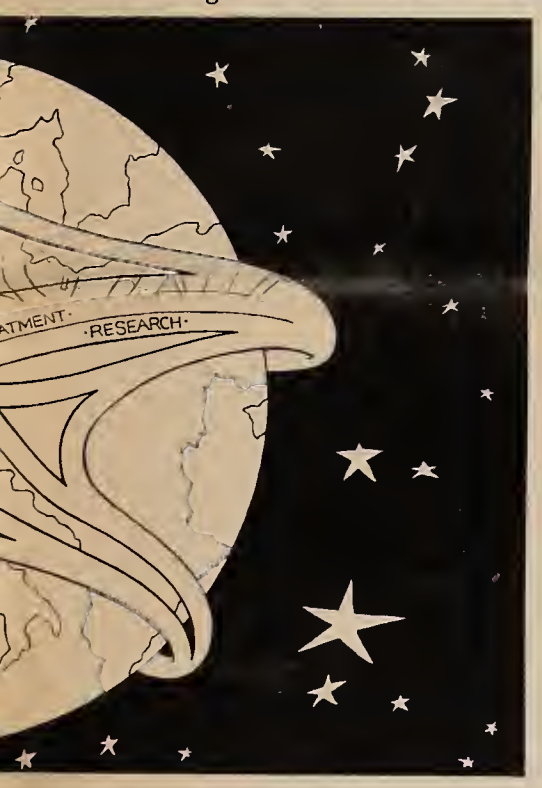
Near misses

• Collaborating centres

Recognizing that much of the work, both national and international, in the field of drug problems is carried out independently of UN bodies, the WHO, in a policy statement issued in 1979, outlined a plan to develop collaborative relationships with a number of well-developed centres of excellence throughout the world.

It was recognized that the WHO and other UN organizations do not, by themselves, have sufficient resources, monetary or human, to meet the need in developing countries for technical knowledge and experience; examination and evaluation of programs, policies, and priorities; and, training of professional and non-professional personnel. It was recognized also that special drug-dependence research and training centres, external to the WHO, contain a considerable body of knowledge and experience, together with a critical mass of professional people that can and should be used to greater advantage internationally.

Collaborating Centres for Research and



Training in Drug Dependence were designated by the WHO in Canada, the US, Mexico, Malaysia, and Thailand and some important projects were developed. For example, the WHO and the ARF brought together an expert working party to consider the basic health and social consequences of cannabis use. A major 'state of the art' report was made available to all member countries of the WHO.

However, in spite of some excellent projects undertaken by these centres, the overall plan may not have lived up to the original expectation of becoming a truly effective coordinating and planning mechanism to facilitate rapid transfer of research data and experience to developing countries. No planned comprehensive program and set of priorities have been developed in association with the collaborating centres, although a few, brief planning meetings have been tagged onto other meetings.

• International Conventions

Recently the WHO, in association with an international NGO and a WHO collaborating centre, collaborated in projects to review the international Conventions. This stemmed partly from the recognition that scant attention had been paid to evaluating the effects of treaties on drug use and abuse, nationally or internationally. Thus, two separate working parties were established to review the experiences of various countries with these two treaties.

The recommendations were addressed to the CND, other international organizations, and national governments and presented to the CND — one in February, 1981, and the second in February, 1983.

To date, there has been no critical review by UN agencies, although the development of a new convention to deal with trafficking, following an initiative from Latin American countries, does answer the intent of a few of the recommendations.

• Data management

Recently, the WHO provided leadership in developing a low-cost, widely applicable method of surveying student drug use.

Many countries have gathered different types of data, using different instruments and methods. The WHO assembled a team of experts from various parts of the world to develop a standardized questionnaire that would be of practical use in various age groups and in different countries. Experts from India, Pakistan, Nigeria, Mexico, Malaysia, Burma, Thailand, the US, and Canada participated in the project.

Some negatives

The dramatic, worldwide expansion of drug trafficking, drug abuse, and drug dependence since the development of the Single Convention and the Psychotropic Convention indicates a relative failure of the international community and the national authorities to find effective methods of curtailing the spread of drug use and abuse. Inadequate financial support, poor communication, inefficient and ineffective information transfer systems, and lack of recognition and/or acceptance of the importance of effective collaboration have been some of the contributing factors.

• Absence of collaboration

A glaring example of the negative consequences of non-collaborative action occurred with the move to eliminate opium smoking in Laos, Thailand, Hong Kong, and Iran.

In Laos, pressure from other countries led to a massive crackdown on opium smoking and the opium dens that were common in the larger cities, particularly in Vientianne. However, little money was made available for treatment of people forcibly removed from their opium. No detoxification centres or outpatient clinics were established, and health professionals were consulted little, if at all. One senior military official expressed his doubt about the policy: "They want to outlaw opium smoking. But if they outlaw opium, everyone in Vientianne will turn to heroin." A prophetic statement. Most of Vientianne's opium smokers did turn to heroin.

In Thailand, similar pressure from the international community led officials to outlaw opium in 1958-1959. And, a great increase in heroin use followed. In Hong Kong and Iran, similar action was taken, and the same negative consequence followed.

Shortly after this policy was implemented, an increase in production of opium in the Golden Triangle occurred, particularly in Burma. Higher-quality heroin was developed and, for the first time, production of opium and heroin in the Golden Triangle was linked directly to markets in Europe and North America.

• Lack of information exchange

Experts tend to dwell exclusively on problems associated with particular substances and fail to share information concerning problems with different substances. Thus, papers are presented, seminars and conferences are held on alcohol, tobacco or other drugs, and groups seldom consider opportunities to learn from the knowledge and experience acquired by those working with other substances.

In 1967, the WHO expert committee attempted to rectify this: "The committee recommends problems of dependence on alcohol and dependence on other drugs should be considered together because of similarities of measures required for prevention and treatment."

Moreover, 'lifestyle' illnesses are now viewed by some policy makers, particularly in the developed countries, as the next major challenge to public health. Exeessive use of alcohol, tobacco, and other drugs, are in the forefront of this challenge. Sharing ideas, experiences, and knowledge about all dependence-producing substances must be of substantial benefit for all concerned.

• Legitimate drug use

Achievement of a balance between the demand for and supply of both narcotic and psychotropic drugs for legitimate purposes requires group coordination and effective exchange of information among governments.

Leakage from licit opium supplies in Turkey to the 'French Connection' was of great concern to the US in the late 1960s. Thus, the US government gave a subsidy of US $34,000,000 (Cdn $46,886,000) to the Turkish government to halt all opium poppy production. This led to a shortfall in opium supplies. The suddenness of the cutoff caused havoc in the farm economy of the poppy growing regions of Turkey.

Certain governments then unilaterally took steps to increase supplies and, in so doing, over-reacted to the temporary shortfall.

Turkey, under pressure from the farmers, returned to the production of poppies, but, under pressure from the UN, used an extraction method in which only the capsules of the plant were processed (sometimes referred to as harvesting poppy straw). This method requires an industrial process, thus making it possible to avoid prohibiting the production of easily smuggled opium, obtained by lancing the seed capsules. A substantial oversupply resulted.

In part, this was due to an absence of consultation, coordination, and exchange of information among governments. The UN has subsequently taken action and requested the INCB do a detailed study and to recommend a concrete program to achieve a lasting balance between supply of, and demand for, narcotic drugs for legitimate purposes.

• Lack of resources

At an international meeting in Canada, participants from several developing countries described a serious problem of uncontrolled 'dumping' of psychotropic substances in their countries. In some instances, psychotropic drugs were shipped from an intermediate country where goods had been repackaged and falsely labelled. Some countries had received large quantities of drugs that were illegal in the country of origin or did not meet safety and purity standards.

This problem is compounded because developing countries frequently do not have the manpower or mechanisms needed to administer some provisions of the Convention on Psychotropic Substances or to enforce quality control of standards. Recordkeeping by pharmacies, physicians, and importing agencies is required to monitor the distribution of drugs in a country.

When the priority is primary health care, it is difficult to budget adequate funds for the administration of the Psychotropic Convention. Furthermore, the difficulties of administration in these countries may be even greater than in developed countries because of the lack of qualified personnel to administer national laws required by the Convention and to enforce them effectively.

In such instances, international collaboration to develop appropriately trained manpower is urgently needed along with financial aid from developed countries.

• Data on international treaties

The Single Convention on Narcotic Drugs has been ratified by more countries than any other international convention established by the UN.

However, examination by the previously mentioned working parties indicates the information base was inadequate to evaluate the effectiveness or non-effectiveness of the treaties. Furthermore, the working parties were concerned that — despite the provisions of the Conventions and the accumulation of drug-related data in other UN organizations and agencies and within countries — no adequate research and analysis has been completed to assist the CND or the INCB in policy development or in the evaluation of developing patterns and trends in drug abuse.

• Lack of promotion

The Convention on Psychotropic Substances has had a slow rate of ratification. There has been considerable reluctance by a number of nations — particularly developed nations. There is evidence that many countries require more information about the Convention and what has to be done to implement it.

International research

There is an urgent need for further development of international collaboration in research. Collaboration and comparative studies expose investigators to a broad array of variables and encourage the search for common denominators, with the prospect of leading to useful generalization.

The practical value of observing results of a range of policy options for drug control or for organization of preventive measures and treatment systems is that effectiveness and other consequences can be predicted on the basis of actual experience, rather than simply hypothetical considerations.

There are numerous examples of important projects undertaken with WHO leadership, involving WHO collaborating centres, non-governmental organizations, and various countries:

- development of core data for epidemiological studies of non-medical drug use involved representatives from nine countries plus governmental and non-governmental agencies,
- a critical review of drug abuse reporting systems led to recommendations for the improvement of data reporting systems,
- an international team from five countries developed and tested an epidemiological research instrument in a variety of languages and settings, and
- a review of the socio-cultural context of drug taking involving some 35 collaborators from 20 countries.

The WHO is now proposing new procedures, including annual meetings of a program-planning working-group in addition to the meetings of the expert committee on drug dependence. Greater emphasis is to be placed on collaboration with other governmental and NGOs — particularly the pharmaceutical industry — to obtain more data for the WHO review process.

These proposals were submitted to the WHO executive board in January. Nevertheless, the importance of a substantial expansion of the WHO's capacity to provide leadership in the further development of international collaborative research must be emphasized.

A catalogue of studies that would be useful to the international community can be constructed easily, including:

- an examination and comparison of the impact (or lack of impact) of research investigation on policy decisions in various countries,
- comparison of factors contributing to the rise and fall of drug 'epidemics,'
- studies of the economics of illicit pro-

Continued on page A4

FROM: The Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse

Narcotic and Psychotropic Drug Problems: International Collaboration on Health Aspects

duction and its impact on the producing countries, plus the implications for the international community,

- evaluation of the impact of crop substitution, combined with primary health care, on the producing communities,
- studies of various strategies used by international drug traffickers in maintaining and expanding the illicit drug supply system,
- international comparisons of the adaptation of prevention and treatment strategies to various cultures,
- collaborative projects directed toward development and application of research instruments and methods in different countries and,
- development of simplified epidemiological methods for application in developing countries.

The need for substantial expansion of international collaborative research is clearly evident. Unlike some other strategies, much scientific enterprise is truly international in character, and this characteristic has led scientists the world over to seek opportunities to exchange information, share experience, review critically work of colleagues completed or in progress, and, where indicated, to undertake collaborative projects.

Ministries of health the world over should encourage the WHO in this enterprise and provide the financial resources to make the development possible.

Recommendations

Whereas earlier drug control Conventions were concluded at a time when international legislators were not aware of the complexity of the drug abuse problem and really believed that they could "solve the problem" of drug dependence by administrative controls and measures of penal law, the world community is now fully cognizant of the wide range of related economic, social, and health issues.

No one is now under the illusion that administrative measures by themselves will be sufficient. The need for mutual assistance and collaboration, nationally and internationally, has never been greater. The opportunities for collaboration are many. What is needed is the political and bureaucratic will to ensure that it happens.

1. National coordination — The need for a national coordinating mechanism is well recognized. However, examples are rare where an effective mechanism, involving various departments of government, has been established *without* clear leadership and direction from the senior level of government — frequently the head of state.

Ideally, a national coordinating mechanism should be operational, multidisciplinary, and link all activities related to drug abuse in the country. It should have legislatively defined authority and responsibility, be the established leadership body for the country, and be responsible for liaison and coordination with international organizations and other countries. It should report directly to the head of state or an appropriately constituted cabinet committee.

In view of the severe impact of drugs on the population, particularly the young, it is recommended *strongly* that ministers of health provide the impetus and leadership to establish effective coordinating systems with specific legislative responsibilities and reporting to the highest level of their governments.

2. Comprehensive programs — In view of the need to ensure that intervention programs in countries producing opium and coca bush are comprehensive — consisting of basic health and education services together with crop substitution — it is recommended that ministers of health support strongly, through their national governments and the relevant international organizations, particularly the WHO, the need for basic health and education programs to be developed wherever and whenever crop substitution programs are to be implemented.

3. WHO collaborating centres —The WHO plan for collaborating centres called for development of a truly effective coordinating and planning mechanism to facilitate rapid transfer of research data and experience to the maximum benefit of developing countries.

As this plan has not been realized, it is recommended that a working group be established with representation from selected ministries of health, the WHO, and WHO collaborating centres, with two main objectives:

- to document the professional resources and program priorities of the WHO collaborating centres potentially available and useful for international programs of research, training, and information transfer, and
- to develop a strategic plan involving the WHO and appropriate collaborating centres, with clearly stated objectives and priorities, designed to use to best advantage the human resources and thereby improve the ability of the community of nations in their efforts to suppress the problems associated with drugs.

4. Removing the barriers — The common features of dependence add strength to the contention that the barriers to communication between different substance constituencies should be abolished to aid in the identification of common issues and intervention strategies. Thus, it is recommended:

- ministers of health take action to promote collaboration between and among the different substance constituencies,
- the WHO and selected NGOs establish a working party to identify the major issues and intervention strategies common to the different constituencies, and
- one objective be clarification of programs that may best be developed collaboratively between and among various substance constituencies, the WHO, and selected NGOs.

5. Information, knowledge, experience — Basic to the development of genuine international collaboration is an increased willingness to take account of experiences from countries and organizations other than one's own.

Much more open exchange of ideas is needed as a forerunner to the development of better understanding and mutual respect between different systems and philosophies, provided that one dominant cultural view is not superimposed.

There is a great need for better understanding of both the impact of drugs on different cultures and useful strategies required to approach the problem within cultural norms and values.

It is therefore recommended that ministers of health should take the lead in promoting and creating more frequent opportunities for information exchange and for the development of collaborative enterprises designed to counter more effectively the well-organized, well-developed, and efficient criminal organizations seeking to create more addicts and to distribute drugs for financial gain. Some specific areas in which exchanges of experiences are needed and strategies for such exchanges are:

- ***Treatment and rehabilitation*** — Conferences or working parties should be set up to determine which of the many treatment modalities is more effective for what kind of patient, in what cultural setting, with what kind of drug problem, under what conditions and circumstances, and why. There is now sufficient knowledge and experience to state that no single modality of treatment will be effective for all kinds of drug-dependent people. The need is for clarification leading to improvement in treatment and rehabilitation programs throughout the world.
- ***Training program*** — Both the WHO and the ICAA have had substantial, positive experience in developing training programs, the WHO on short courses for physicians and the ICAA on courses for multidisciplinary groups and the 'training of trainers.' The DND has concentrated on training law enforcement officers and has developed some education programs for community-based personnel. Most of these training programs have been carried out with no significant collaboration among the three organizations. If a true partnership could be developed among them, then scarce financial and human resources could be used to greater advantage and benefit for a larger number of countries. Moreover, in view of the wholly inadequate financial and human resources available, governments and NGOs should be encouraged to develop training programs on a regional basis, wherever there are sufficient cultural similarities.
- ***Adaptation of information and public education*** — There is an avalanche of public educational material on all aspects of the drug problem, published primarily in developed countries. This material might well be adapted or easily translated for use in developing countries, many of which do not have the human and financial resources even to review and select what they might need. A UN organization, such as UNESCO, or an NGO such as the ICAA, or perhaps a regional body such as the Colombo Plan bureau, could select educational literature relevant and adaptable to various countries and cultures in the developing world.
- ***Expert groups*** — There is common agreement that decisions about what to do about drugs should be based on as much information as possible about the nature and extent of the problem in a given country, and the latest scientific findings concerning the health and social consequences of various classes of drugs. This information is necessary to enable governments to make informed policy decisions. The latest scientific findings should be made as widely available as possible, as rapidly as possible. Working parties, such as those convened by the ARF in collaboration with the WHO and the ICAA, provide an effective and efficient model to tackle well-defined topics. A series of concise reports on selected, well-defined issues would be of great service to the international community. The WHO together with one or more WHO collaborating centre and selected NGOs should receive support for and provide the leadership for this development.
- ***Ratification of the Convention on Psychotropic Substances*** by a larger number of countries would improve international efforts to reduce the negative impact of psychotropic drugs. Ministers of health are in a strategic position to promote this and should be urged to do so. The DND should be encouraged to prepare an explanatory document summarizing the major features of the Convention in all official languages — a document that should be concise and comprehensible to non-expert readers — for distribution to all those working in the field, to libraries, and to the general public.

6. Data integration — Every country should be urged to develop as much information as possible about the nature and extent of the drug problem within its borders.

This does not necessarily mean sophisticated epidemiological surveys. There are simplified mechanisms whereby a government can obtain a reasonable idea on whether or not a drug problem of some significance exists. Health and social service systems can provide information on the number of people using drugs, the kinds of drugs used, and the health impact on those who appear in hospitals, outpatient clinics, public health units, and social agencies.

This information, together with data from the police, will provide some indication of the extent and nature of drug use and abuse in the country. In addition, the WHO has developed a simplified, low-cost instrument for surveying drug use among school populations, easily adaptable to different national and cultural circumstances.

The use of this research instrument would enhance the ability to compare data across national and regional boundaries and thereby provide a basis for determining the results of various interventions. This information could be used also to monitor trends in drug use and associated health and social damage.

Ministries of health, the WHO, NGOs, and other concerned organizations should promote vigorously the gathering of these data and the use of the WHO survey instruments.

Numerous epidemiological surveys confirm the prevalence of alcohol and other drug problems is frequently linked to crime, disruption of family life, child neglect, divorce, poverty, and other social problems. All of these conditions thrive in districts where the population has been relatively mobile (eg, urbanized) and, as a consequence, the social cement has been weakened, relationships have become impersonal, and social and cultural controls reduced to a minimum.

Ministries of health should provide leadership in the development and maintenance of a perspective that sees drug problems within the wider context of other major health problems, including family and community circumstances. They should note that in developing countries especially, drug education and rehabilitation programs should, wherever possible, be integrated with existing programs, such as primary health care and public education.

7. Better follow up — The WHO, the CND, and other international organizations issue numerous reports containing many recommendatitons to member governments and other constituencies. Seldom is there any feedback as to whether the content of the report has been understood, or what action, if any, will be taken. There is evidence, for example, that a fundamental understanding of the purpose and provisions of the international Conventions is not widespread, even among those agencies and organizations involved in a wide variety of anti-drug programs in the law enforcement, treatment, and prevention fields. It has been stated communication occurs only when a person hears or reads and understands the message put out by the sender. Effective promotion and follow up is an important part of communication. It would be useful to undertake a project to follow the distribution paths of a number of specific recommendations to a number of countries to learn what happens when the reports arrive. Have they been read? Has any action been taken? What is needed to improve understanding?

8. Oversupply of legal opiates — A strict health solution to the problem of oversupply of legal opiates could be met by developed countries, perhaps through international aid agencies, buying up the supplies of codeine from stocks in Turkey and India and distributing them to the least developed countries as part of the WHO essential drugs program.

The complete text of Mr Archibald's paper, including a bibliography and lists of relevant organizations, is available to readers through **The Journal.**

NEWS

Effective prescribing balances benefits and risks

Adverse drug reactions tied to falls by elderly

By Joan Hollobon

TORONTO — Falls by elderly people are increasingly becoming recognized as a common adverse drug reaction, says a Toronto medical professor.

Psychotropic drugs, antihypertensives, and diuretics are among the medications most commonly implicated, Cyril Gryfe, MD, told the 8th annual Drugs and Geriatric Care conference here. Dr Gryfe is medical director of the Baycrest Centre for Geriatric Care here and an associate professor of medicine at the University of Toronto.

Phenothiazines and tricyclic antidepressants can cause cardiac arrhythmias, while benzodiazepines may reduce alertness. Psychotropic drugs can also affect motor function. Phenothiazines particularly can cause Parkinson-like symptoms, with the typical rigidity and difficulty in initiating movement, that often results in falls.

"There are very few studies to answer the question 'Do drugs cause falls?' so we have to do some inferential thinking," Dr Gryfe told some 200 nurses, pharmacists, doctors, and other health workers.

For example, a person whose blood pressure is being controlled by diuretics or antihypertensive drugs is at risk of orthostatic hypotension — an abrupt, excessive drop in blood pressure on standing too suddenly.

This recognized side-effect has rarely been connected with falls among older people, Dr Gryfe said.

Disturbances of heart rhythm, sometimes associated with long-term use of diuretics and with psychotropic drugs, also have not been sufficiently studied as a possible cause of falls among the elderly.

Older patients: judicious treatment takes a skill more demanding than writing a prescription

"And, if the tricyclics can cause arrhythmias and the arrhythmias can cause falls, ergo the tricyclics cause falls," he said. "That has to be the accepted logic until somebody comes up with a good study."

Falling may, however, be a clue to underlying illness — an indication for prescribing a drug rather than discontinuing one.

Effective prescribing requires that drug benefits be weighed against drug risks. Extensive epidemiological studies are needed to determine the types and doses of drugs most likely to put the elderly at risk, he said.

Meanwhile, there are things that can be done to protect the old; deaths attributed to falls have actually diminished substantially in recent years.

Dr Gryfe's major advice: "Make drug use as rational as possible," and warn elderly patients starting a new drug they may experience lightheadedness.

"Warn them not to jump out of bed or up from a chair, but to do it deliberately and cautiously."

Dr Gryfe told **The Journal** that although there has been a cutback generally in the use of tranquillizers, these drugs "are probably still being used in excess because the pharmaceutical industry still keeps coming forward with, 'Well, we've got a better one now.' "

Many physicians are also still less aware than they should be that old people generally require lower doses of drugs than younger people, Dr Gryfe said.

"There's a place for drugs, but they must be used judiciously. I don't think it is a matter of drugs being used for too many old people, I think it is a question of 'Why do we turn to drugs first?' There are other ways of treating people — talking to them, making their aspirations fit their limitations when we know there is nothing we can do.

"And, we can point out to them, 'Yes, we know you are having pain, but the risk of taking the drug might be greater than the pain. So think about it.' That takes time, it takes a skill that is much more demanding than writing a prescription, and, if I'm a busy physician in an office with people waiting in my waiting room, I'm going to take the easy way out," he said.

Dr Gryfe attributed the general cutback in prescribing benzodiazepines and similar drugs to "a very powerful campaign — the federal government spent a lot of money to try to make the health care industry aware of this, and I think it has had its impact."

Smokeless tobacco no better: US

WASHINGTON — Smokeless tobacco products are not a safe substitute for cigarettes and are a cancer risk, a report by United States Surgeon-General Everett Koop warns.

The report, similar to one issued in 1964 on cigarettes by a former US Surgeon-General, said oral use of smokeless tobacco represents a significant health risk.

It is estimated at least 12 million people in the US used the products in 1985.

The report says smokeless tobacco "can cause cancer and a number of non-cancerous oral conditions and can lead to nicotine addiction and dependence." Use is on the increase, particularly among boys and young men, the report adds (The Journal, March).

HOWELL

The story that got away

There are two regular columns in **The Journal**, one labelled Gilbert, the other labelled Howell. They could just as easily be labelled Sense and Nonsense, since Gilbert is demonstrably guilty of the former, and, if I were ever formally charged with the latter, I would cop a Spiro Agnew plea of *nolo contendre*. But notwithstanding that, I have my pride.

Readers of Gilbert's recent two-part series on betel-nut use (April, March) might easily conclude Gilbert was the first intrepid columnist from **The Journal** to sample an exotic drug in the interests of science and journalism (he sampled a betel-nut mixture in a Toronto betel-nut emporium), never realizing the senior columnist (me) had embarked upon a similar venture more than a decade ago, in the heart of darkest Africa.

It is true my venture came to grief, and never resulted in a column in **The Journal**, but that failure was not my fault. It was the result of the awesome power of a certain publication. Let me explain . . . .

In 1975, I visited the African kingdom of Swaziland, which has been much in the news of late because Mswati III, one of the many sons of the late King Sobhuza II, has just been crowned reigning monarch in an impressive ceremony before foreign dignitaries.

On my 1975 visit to Swaziland, I stayed with an anthropologist who described to me certain witch-doctor, healing-rituals to which she was privy because of her connections and interests. These rituals involved much chanting and drum-thumping and culminated in the inhalation of certain miraculous substances that produced trances of varying degrees and the kind of healings that would put most television evangelists to shame.

The anthropologist was a little vague about the details, having only viewed the rituals from a respectful distance, and could therefore only surmise that while *cannabis sativa* appeared, given the aroma, to be part of the matter, it was not, as Graham Greene would say, the heart of the matter.

Naturally, my interest was piqued. And when she said she would try to arrange to have me participate in one of these aboriginal seances, my interest was piqued even more. Forget Graham Greene — like Conrad, like Stanley, like Livingstone, I would journey to the heart of darkness, the heart of the dark continent, and report it all in **The Journal**.

I was wound up and ready to go. Unfortunately, I was so wound up I ran off at the mouth. I could not resist telling her readers of **The Journal** would get a blow-by-blow account of my exotic experiences.

What, she asked, was **The Journal**, and who were its readers? In retrospect, I should have smelled trouble with this query. But, I didn't and I answered the question honestly: I said it was basically a North American special-interest news publication for professionals, with a small but significant (what a fool I was) international circulation. What kind of international circulation? Well, I had once got a letter from a reader in New Zealand, and I had once met a fellow from Australia who said, "I read your stuff, mate."

At that point, the non-nitrogenous waste hit the oscillating air-circulation device. Did I not realize the anthropologist's husband was working in Swaziland as a guest of the government?

Did I not realize that the Swazi government was trying its best to maintain cordial relations with the Republic of South Africa and doing its best to keep off the record the fact it was the number one supplier of quality cannabis to that regime, a record already sullied by the well-known fact that Swaziland openly provided certain diversions for South African whites that they could not get in their own country — casino gambling, pornography, and opportunities for inter-racial sexual liaisons? What if Sobhuza II were to read my article in **The Journal** and was displeased by it? What international repercussions would ensue?

I had just come from *Incwala* (National Ceremony) at the royal village of Lobamba, where I had seen the 76-year-old Sobhuza II resplendent in his glory (he was wearing a loin-cloth and his lithe brown body looked not a day older than 50). Being aware of the recent dissolving of parliament and the king-ordered incarceration of certain troublesome democrats, I could appreciate her concern. But after just having witnessed a slide show of the July *umhlanga* (reed dance), during which the octogenerian monarch had selected another consignment of virgins as royal wives, I suggested that, notwithstanding the great erudition and inquiring mind of Sobhuza II, it would be more likely that he would be preoccupied with his recent acquisitions than columns in **The Journal**.

In my own inimitable way, I tried to make light of the situation, suggesting if Sobhuza II were feeling bored and restless, he would be more likely to suggest to The Great She Elephant (his number one wife) that she send up a couple of umhlanga-lovelies rather than milk, cookies, and the latest copy of **The Journal**.

But, my anthropologist friend would have none of it: you never know, said she. What if my column reared its ugly head in Swazi reigning circles and caused an international incident, and Canadian nationals had to sneak ignominiously out of Africa, like United States Peace Corps volunteers? All because of an intrepid columnist from **The Journal** looking for a Third-World exclusive. It was a cross she was not willing to bear.

She was serious, and I couldn't talk her out of it. There would be no witch-doctor seance arranged by her, not if it were to result in a column in **The Journal** that might shake the very foundations of the Global Village. So, I deferred to her better judgement. And consoled myself with the fact that guys who wrote for *The New York Times* and *The Manchester Guardian* probably had the same problems I did.

By Wayne Howell

NEWS

Women under work-stress can't quit smoking

PHOENIX — Women have more trouble quitting smoking than men, but the reason remains unclear, says Calvin Fuhrmann, MD, chief of pulmonary medicine at South Baltimore Hospital, Maryland.

In the past three or four years, he has seen almost 1,000 people who want to quit: "We are running a 36% success rate in women, a 55% success rate in men, for a combined rate of a little better than 40%."

Dr Fuhrmann told **The Journal** during the annual meeting of the American College of Allergists here that the lack of success women have in quitting smoking is an international phenomenon (**The Journal**, May).

"I don't have a physiologic reason. I have been doing extensive psychological testing in all of our subjects, but we just have not pinpointed it.

"Perhaps it has to do with stress. We do treat women executives, so we are treating women in our programs who have a job all day and then go home and take care of their families. Perhaps that double dose of stress is the reason we don't have as much success as we do with the men."

Dr Fuhrmann said successful quitters are also those people with medical problems — and likely in the hospital and away from cigarettes. Or, smoking parents of asthmatic children may quit for the sake of their offspring.

Dr Fuhrmann has developed a formalized program for prospective quitters. Participants undergo a battery of tests, including psychological stress tests. Carbon monoxide levels are measured as well as blood pressure. Blood screening is conducted to ensure the safety of prescribing nicotine-laced chewing gum as an adjunct to treatment.

Patients attend the clinic for about two hours, once a week, for eight weeks. The first four weeks lead up to their quitting smoking.

Dr Fuhrmann: "During that time, we show people why they smoke, when they smoke — to get them in touch with their habits.

"We also subject them to some pressure, in the sense that in week two we say, 'You cannot smoke at home.' Then we have a quit night. We have them stop smoking cigarettes and start chewing the gum."

As weeks progress, patients are advised about potential problems with the gum, such as mouth ulcers, adhesion to dentures, or a feeling of nausea.

The final two weeks of the program are simply a stress management course. Dr Fuhrmann: "We find that the techniques they need are not only using the gum, but using some relaxation techniques so that they don't resort to cigarettes."

Manitoba MDs want extra cig tax

By Maureen Brosnahan

WINNIPEG — Manitoba doctors will ask the provincial government to impose an additional "penny-a-pack" tax on cigarettes with the money used for a smoking prevention campaign aimed at young people.

The resolution was passed at the annual meeting here of the Manitoba Medical Association (MMA).

Lloyd Bartlett, MD, of the MMA's executive, said if the government agrees, the move will mean $1 million could be collected for the plan. He said the goal of the campaign would be to discourage young people from smoking or starting to smoke.

"I don't see why anyone would disagree with that, even smokers," he said. "Every smoker would say to young people, 'Don't start.'"

Dr Bartlett added he didn't think the public would object to a one-cent increase in tobacco prices.

Even though the Canadian government has an ongoing campaign — A Generation of Non-Smokers — directed at discouraging young people from smoking, Dr Bartlett said there's always room for more promotion.

He said the province could conduct a campaign, with input from various community groups, that would complement the federal promotion.

US docs say lower BAC

CHICAGO — The American Medical Association (AMA) in the United States is urging all states to reduce by half the blood alcohol level at which a driver should be barred from driving.

The January 24/31, 1986 issue of the *Journal of the American Medical Association* includes a report from the AMA's Council on Scientific Affairs urging a blood alcohol concentration (BAC) of 0.05% be considered the legal limit for drivers.

This level became the AMA standard after it was adopted by the AMA's house of delegates, the organization's policy-making body, during last year's annual meeting.

The council's report said a driver with a 0.05% BAC has the same probability of causing a crash as a sober person. However, the probability rises sharply starting at the 0.05% level.

East coast CAF office

FREDERICTON — Atlantic Canada has its first chapter of the Canadian Addictions Foundation (CAF) with the formation of a group in Campbellton, New Brunswick.

Joseph MacIntyre, CAF Atlantic regional representative and national treasurer, welcomed the step as a promising sign in the face of the degree of apathy about alcohol and other drug issues evident in the area.

Mr MacIntyre said CAF chapters "provide a nationally recognized vehicle for change" when dealing with drug issues in a local area.

Present laws are among the toughest in Europe

Norway to strengthen anti-smoking legislation

By Thomas Land

OSLO — Norwegian officials are preparing tough new legislative proposals to restrict smoking in public places.

Existing anti-smoking law in Norway is among the toughest in Europe, and an authoritative survey recently conducted by the United Nations World Health Organization (WHO) suggests the Nordic approach has already saved many lives.

Norway's Restrictive Measures Act for the Marketing of Tobacco Products was passed in 1973, prohibiting tobacco advertising in all mass communication media. Public health authorities and pressure groups in many countries would like to follow suit.

Recently, the Canadian Lung Association urged Ottawa to use the Norwegian law as a model for similar legislation at home (**The Journal**, December, 1985).

But, Norway is about to go much further.

Its legislative proposals are being drafted cautiously because the government is anxious to balance citizens' right to personal freedom with their right to protection from tobacco fumes. The new law is expected to grant health authorities sweeping powers to restrict smoking in public places.

The National Anti-Smoking Association, which enjoys great sympathy from, and the approval of, the government, has just published a program to turn Norway into a smoke-free society by the year 2000. The program was drawn up at the request of the government.

It prescribes a substantially increased tax on cigarettes to raise money to help people stop smoking. And, it proposes drastic restrictions on the sale of tobacco products be put into effect toward the end of the century, limiting the trade to a small number of state-owned outlets.

Golobitsh

Public smoking: balancing personal freedom with rights to clean air

Scandinavia's efforts to kick the tobacco habit have attracted great interest worldwide. The results show, says the WHO in an important recent analysis, that anti-smoking campaigns really do work.

When the 1973 Norwegian tobacco law came into effect, the proportion of males smoking each day was estimated at 52%. By 1982, the proportion had fallen to 40%.

In neighboring Sweden, where strong health warnings on cigarette packets were introduced in 1975, the proportion of people who smoked at least once a day declined to 31% from 43% in five years. Among 13-year-old boys, the number who smoked fell to 5% in 1980 from 14% in 1971, and for 13-year-old girls, the drop was to 6% from 16%.

A WHO spokesman says: "Even in countries with more limited legislation and programs, there has been a marked decline in smoking. In Canada, tobacco consumption in 1983 decreased substantially — probably reflecting the large price increases for cigarettes in the two previous years.

"In the United States, the proportion of smokers declined to 33% from 42% between 1965 and 1980. The proportion of boys aged 17 to 18 years who smoked fell to 20% in 1979 from 30% in 1968; among girls of the same age, an initial increase to 25% from 18% in 1977-1978 seemed to have levelled off by 1979.

"The effectiveness of national smoking control programs in reducing tobacco-associated diseases can only be measured over many years. But, one study among male doctors in Europe shows that a reduction in smoking to 21% from 43% between 1954 and 1971 was followed by a reduction of 25% in deaths from lung cancer over this period."

Airlines experiment with non-smoking flights

STOCKHOLM — Smoking control efforts are gearing up as airline officials voice increased concern about the quality of air in the air.

Sweden's domestic airline *Linjeflyg* has banned smoking on all flights, becoming the first carrier in Western Europe to do so.

Other airlines, however, are expected to follow Linjeflyg's experiment with interest. Three years ago, the Soviet airline *Aeroflot* banned smoking on all domestic flights. At that time, the Association of European Airlines rejected formal proposals to ban smoking on short-haul flights (**The Journal**, August, 1983).

In April, Air Canada became North America's first major airline to introduce non-smoking flights, banning smoking on more than half of 76 daily flights in the Montreal-Ottawa-Toronto triangle.

Linjeflyg's change to smoke-free service follows years of complaints from cabin personnel, both smokers and non-smokers.

"The atmosphere in an aircraft cabin is drier and has a higher ozone level than normal," says a statement from Linjeflyg's chief physician. "This in itself, is not dangerous. But, it causes irritation to the mucous membranes, a problem magnified by smoke."

Airlines favor smoke-free flights for many reasons, including safety, economy, health, and hygiene. But, they fear resistance from passengers who smoke.

In a survey of Linjeflyg's passengers, 93% said they were willing to travel on smoke-free flights lasting 40 minutes or less, and 80% would accept an unconditional ban on smoking on all the airline's services.

DEPARTMENTS

New Books

by MARGY CHAN

Drug and Alcohol Law for Canadians (Second edition)

. . . Robert Solomon, Tracy Hammond, and Sharyn Langdon.

The handbook provides basic information about alcohol and other drug laws in Canada, the related Ontario legislation, and the legal consequences of their violation. Its purpose is to assist the general public in making informed and responsible choices about alcohol and other drug use.

Addiction Research Foundation, Toronto, 1986. 119 p. $15. ISBN 0-88868-113-5.

Alcohol Use and Alcoholism: A Guide to the Literature

. . . Penny Booth Page

This is a useful annotated compilation, for the general public, of materials on alcohol use and alcoholism. It includes books, pamphlets, leaflets, and government documents published mostly from the mid-1970s to 1985. Journal articles and audio-visuals are excluded. The bibliography is divided into chapters representing different aspects of the topic: alcohol problems in the family, alcohol and traffic safety, legal and social issues, etc. A good, general introduction, is given, as well as author and title indices, a directory of organizations for further information, and a list of periodicals dealing with alcohol.

Garland Publishing Inc, New York, 1986, 192 p. $26. ISBN 0-8240-9020-9.

Directory of Alcohol and Drug Treatment Resources in Ontario, 1986

. . . edited by Catherine Blake

This is an annual update of a province-wide survey by the Addiction Research Foundation's community services division. Twenty-one new agencies have been added to this edition. Two main categories are covered in the book, which is a basic reference directory to the Ontario addictions field: addiction-specific resources and general resources. Program descriptions are arranged by geographic region. There are various indices to identify programs by treatment type and client type.

Addiction Research Foundation, Toronto, 1986. 464 p. $20. ISBN 0-88868-128-3.

Other books

Drug-induced Nutritional Deficiencies, 2nd ed. — Daphne A. Roe, 1985. Chapters in this book include: basic concepts; factors affecting nutritional requirements; variables determining incidence and risk; diagnosis of drug-induced malnutrition; drug-induced malabsorption, iatrogenic hyper-excretion, and tissue depletion of minerals and vitamins; anti-vitamins; fetal malnutrition, abnormal development, and growth retardation; alcohol and alcoholism; nutritional effects of anti-convulsants; nutritional effects of oral contraceptives; nutritional effects of tuberculosis chemotherapy; nutritional effects of anti-Parkinson drugs; nutritional consequences of cancer chemotherapy; and, safety and prevention. AVI Publishing Co, Westport, Connecticut. Bibliographies, index. 336 p. $37.50. ISBN 0-87055-501-4.

Women's Burnout: How to Spot it, How to Reverse it, and How to Prevent it — Herbert J. Freudenberger and Gail North, 1985. The authors examine the phenomenon and causes of burnout in women. Among topics they explore are the differences between depression and burnout, how family demands can contribute to burnout, couples' burnout, business burnout, and how to handle a burned-out individual. Doubleday, Garden City, New York. Index, bibliography. 244 p. $14.95. ISBN 0-385-18803-X.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $24 per year
Air Mail: add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Open Secrets

Number: 735.
Subject heading: Youth and alcohol: impaired driving.
Time: 25 min.
Synopsis: A mother waiting in a hospital emergency ward recounts her version of the events leading up to her son's accident. She had thrown away vodka and marijuana she found in her daughter's room. Worried about her children's drinking, she'd asked her husband to talk to them. At dinner, the father had laughed off her attempts to deal with the issue and her children had denied having any problems. Alison, her daughter, is also waiting at the hospital. She feels guilty because by accusing her brother of taking her "stash" and "being a baby," she might have provoked him into drinking. Feeling helpless, the father does not know what he should have done, nor what to do now. While the mother is saying they must get outside help for their problems, the doctor tells them the young man has died.
General Evaluation: Fair to good (3.8). This film realistically portrays a family coming to grips with its problems. General broadcast is recommended.
Recommended Use: With a resource person, this film could provoke good discussion with parents and older teenagers.

Play Your Hand

Number: 734.
Subject heading: Employee assistance programs.
Details: 35 min, video only, also available in French.
Synopsis: As two employee assistance consultants walk through an office corridor, they observe confrontations between managers and employees. The video demonstrates various techniques for recognizing, documenting, and managing performance problems. The employee assistance consultants review the managers' strategies for conducting effective employee performance interviews.
General evaluation: Fair (3.4). The video replay technique of demonstrating an intervening strategy and then reviewing it is effective, although it doesn't attempt to deal with all contingencies.
Recommended use: With a resource person, the video could be used for management training.

Epidemic: Deadliest Weapon in America

Number: 736.
Subject heading: Impaired driving.
Time: 25 min.
Synopsis: Several people who have been victims of drinking drivers or who have lost family members, are interviewed about the accidents' effects on their lives. The accidents are shown in gory detail. Teenagers drive through an obstacle course first sober and then after having consumed various quantities of alcohol. People are urged to take positive action by starting groups such as SADD (Students Against Drunk Driving).
General Evaluation: Very good (5.0). Although some viewers may find the details emotionally upsetting, the film could lead to good discussion. General broadcast is recommended.
Recommended Use: With a resource person, the film could benefit those 15 years of age and older.

Positions Available

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

86th Annual Meeting Canadian Lung Association — June 13-16, Winnipeg, Manitoba. Information: A. Les McDonald, director, health education and program services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

77th Annual Conference of the Canadian Public Health Association — Health Promotion Strategies for Action — June 16-19, Vancouver, British Columbia. Information: CPHA, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

Canada Safety Council 18th Annual Conference — June 22-25, Victoria, British Columbia. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4.

Summer School for Addiction Studies — July 7-25, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

27th Annual Institute on Addiction Studies — July 13-18, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

International Conference on the Dynamics of Social Change: Implications for Safety — July 29-Aug 1, Edmonton, Alberta. Information: Conference secretariat, Dynamics of Social Change, 171 Nepean St, Ste 600, Ottawa, Ontario K2P 0B4.

American Hospital Association Annual Meeting — Aug 4-6, Toronto, Ontario. Information: John McMahon, president, 840 N Lakeshore Dr, Chicago, Illinois 60611.

North American Congress on Employee Assistance Programs — Aug 5-8, Toronto, Ontario. Information: Diane Vella, 2154 Crooks Rd, Ste 103, Troy, Michigan 48084.

Canadian Socicty of Hospital Pharmacists 39th Annual Meeting — Aug 28-30, Ottawa, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

Canadian Society of Forensic Science Annual Conference — Sept 15-19, Niagara Falls, Ontario. Information: Executive secretary, Canadian Society of Forensic Science, 2660 Southvale Cres, Ste 215, Ottawa, ON K1B 4W5.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

Social Science Federation of Canada Research 86: Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario K1A 0N5.

Event 86 — Skill Development and Training for Employee Assistance Personnel — Nov 16-20, Oakville, Ontario. Information: James Simon, Addiction Research Foundation, Georgian Bay Centre, PO Box 936, 100 Bell Farm Rd, Barrie, ON L4M 4Y6.

United States

Chemical Dependency and Violence Factor: Survivors and Perpetrators of Physical/Sexual Abuse — June 14, Oakland, California. Information: Stephanie Ross, training coordinator, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

48th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 16-18, Tahoe City, California. Information: Mary Jeanne Kreek, Committee on Problems of Drug Dependence, Inc, The Rockefeller University, 1230 York Ave, New York, NY 10021.

National Clergy Council on Alcoholism and Related Drug Problems Annual Meeting — June 16-20, Chicago, Illinois. Information: John O'Neill, executive director, 3112 7th St NE, Washington, DC 20017.

37th Annual Symposium on Alcoholism — June 16-27, Seattle, Washington. Information: Alcohol studies program, Seattle University, Seattle, WA 98122.

Rutgers Summer School of Alcohol Studies — June 22-July 11, New Brunswick, New Jersey. Information: Center of Alcohol Studies, Rutgers University, Smithers Hall, Piscataway, NJ 08854.

Midwest Regional NACoA Conference on Children of Alcoholics: Young, Adolescent, and Adult — June 28-29, Southfield, Michigan. Information: Midwest Regional National Association of Children of Alcoholics conference, National Council on Alcohol/Michigan, 1405 S Harrison, Ste 308, East Lansing, MI 48823.

15th Annual San Diego Summer School of Alcohol and Other Drug Studies — July 6-11, San Diego, California. Information: University of California, San Diego X-001, La Jolla, CA 92093.

17th Annual Narcotic Research Conference — July 6-11, San Francisco, California. Information: E.L. Way, department of pharmacology, University of California, San Francisco, CA 94143.

Street Drugs: Evolution of Current Trends and Overview of Treatment Models — July 19, Oakland, California. Information: Stephanie Ross, training coordinator, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

New Jersey Summer School of Alcohol and Drug Studies — July 27-August 1, New Brunswick, New Jersey. Information: Center of Alcohol Studies, Rutgers University, Smithers Hall, Piscataway, NJ 08854.

Addictions: Weaving the Common Thread, 1st Southwest Institute on Alcohol and Drug Abuse —July 27-Aug 1, Austin, Texas. Information: Judee Arkow, 1705 Guadalupe, Austin, TX, 78701-1214.

National Prevention Conference — Aug 3-6, Washington, DC. Information: Teddi Pensinger, state and community prevention coordinator, National Institute on Alcohol Abuse and Alcoholism, Rm 16C-10, Parklawn Bldg, 5600 Fishers Ln, Rockville, Maryland 20857.

North American Congress on Alcohol and Drug Problems — Sept 7-11, Boston, Massachusetts. Information: Alcohol and Drug Problems Association, 444 N Capitol St NW, #181, Washington, DC 20001.

Alcohol-Related Birth Defects: Implications for Policy— Oct 19-21, San Diego, California. Information: Alcohol-Related Birth Defects Conference, University of California, San Diego X-001, La Jolla, CA 92093.

Association of Labor-Management Administrators and Consultants on Alcoholism — Nov 1-5, Dallas, Texas. Information: ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Abroad

2nd World Congress on Sexually Transmitted Diseases — June 25-28, Paris, France. Information: International Congress Agency, 4, Villa d'Orleans, 75014 Paris, France.

International Symposium on Health Education in Schools —July 6-10, Jerusalem, Israel. Information: D. Tamir, international symposium, PO Box 394, Tel Aviv 61003 Israel.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

10th World Conference of Therapeutic Communities — Sept 7-12, Eskilstuna, Sweden. Information: The United Swedish Foundations, Box 354, S-641, 23 Katrineholm, Sweden.

10th International Conference on Alcohol, Drugs, and Traffic Safety — Sept 9-12, Amsterdam, The Netherlands. Information: Symposium secretariat, QLT, convention services, Keizersgraacht 792, NL-1017 EC Amsterdam.

International Symposium on Young Drivers' Alcohol- and Drug-Impairment: Selective Countermeasure Program Development — Sept 13-15, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, dept of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

International Conference on Addiction — Oct 19-24, Vienna, Austria. Information: Barbara Turner, conference coordinator, Bldg D, Ste 120, 11050 Crabapple Rd, Roswell, Georgia 30075.

Alcohol Problems in Celtic Countries — Oct 30-Nov 2, St Peter Port, Guernsey, Channel Islands. Information: P.J. Lemmon, Guernsey Council on Alcoholism, 50 The Bordage, St Peter Port, Guernsey, Channel Islands.

A tale of false starts and wrong turns

Women and alcohol research: a cluttered legacy

TORONTO — More women are drinking and more are drinking heavily today than 50 years ago. But, there has been little change in the past decade, and there is not likely to be major change in the next, says Kaye Middleton Fillmore, PhD, a senior scientist in the Alcohol Research Group of the Medical Research Institute of San Francisco at Berkeley, California.

Modern social science has found social change to be the most elusive of all topics, says Dr Fillmore.

"While we can document change in retrospect, we are incapable of predicting it with any certainty. For instance, I know of no social scientist who could have predicted the emergence or decline of drug use among the white (United States) middle class in the 1960s.

"I believe, however, we have tentative data that may indicate the age-related patterns of drinking among (US) females may be changing." For the future, she says, the chief research question is: why don't women have *more* alcohol problems?

Dr Fillmore reached her conclusions after an extensive review and analysis of studies and opinion on drinking by women in the last century. Joan Hollobon, contributing editor of The Journal, reports on Dr Fillmore's work, presented to a seminar on Sex Differences and Alcohol at the Addiction Research Foundation's School for Addiction Studies here.

Hollobon

Concern about alcohol problems among women has been relatively rare, says Dr Fillmore. Even the North American Temperance Movement was organized around the issue of men's drinking; women were not a target of interest. Historically, women who used alcohol were seen as prostitutes or, at the very least, promiscuous. Said a study of alcoholics at the turn of the century: "It is probable that in the lowest grade of prostitution, all, with scarcely an exception, are alcoholic."

Since most researchers in the last century reported a sex ratio between four and nine men to one woman, it was concluded about 10% of US alcoholics were women. Only two reports, one (1892) from the US and one (1894) from England, suggested alcohol problems were increasing among women.

The US report, however, reflecting the temperance ideology of the time, optimistically assumed women's "steady upward movement in mental and physical development" would prevent any general increase in alcoholism among them. In contrast, the English report noted increasing numbers of women, some with children or infants at the breast, drinking in bars and public houses.

Dr Fillmore points to similarities between such early literature on female drinking and the literature emerging from the first years of the alcoholism movement.

Epidemiological evidence suggested the incidence of alcoholism among women was lower than among men. Also, alcoholism was so widely considered a 'man's disease,' women were rarely the object of scholarly investigation.

"However, the space of half a century created changes in the status of women and saw the sharp decline of the Temperance Movement and the repeal of Prohibition."

In the 1930s, clinical literature and the press recorded increasing numbers of women being treated for alcoholism.

Dr Fillmore dates modern interest in alcohol problems from the creation in the 1940s of the Yale Center of Alcohol Studies and the success of Alcoholics Anonymous.

At Yale, E. M. Jellinek, whose formulations were central to the scholarly alcoholism work of the period, rejected the notion that more women were being institutionalized for alcoholism. "Female alcoholism is by no means a sign of the times," he said.

His formula for determining the sex ratio of alcoholism dominated the literature until the early 1950s. But, recent evidence suggests his figures of between five and six men to one woman may have underestimated the rate among women.

Dr Fillmore suggests Dr Jellinek may have minimized the prevalence of alcoholism and the likelihood of an increase in problems among women, despite data available, because of the politics of the era, in which Wet and Dry issues were argued heatedly.

"To report alcoholism was increasing among women during this period would suggest an identification with the politics of the Drys, who regarded the availability of alcohol as directly causative of inebriety; to report there was virtually no alcoholism would be, first, to disregard social fact, and, second, to identify strongly with the Wets. Dr Jellinek's sex ratio presented a middle ground."

Dr Fillmore notes the underlying question is: "Why would alcoholism among one half of the society's adults be a cause for alarm while for the other half it was regarded as social fact?"

She says some authors have suggested the answer may lie in the position of women in society, as "the upholders of the moral order."

However, few articles were written on the subject of female drinking and alcohol problems at that time, "probably because it was so firmly established that alcoholics were primarily men." Those articles written treated the condition differently, clearly reflecting "the vision of women in the society" — less vulnerable to alcoholism, but more "deviant" or "abnormal" when alcoholic.

One writer of the era suggested social drinking among women was in itself conducive to alcohol problems. Another, in 1949, considered the source to lie in menopause and depression. Others attributed women's drinking problems to personality disorganization or to sexual dysfunction.

Dr Fillmore: "These explanations have not been lost to history, and the notion that women alcoholics are somehow different from or more abnormal than men alcoholics is still very much in evidence."

Although the idea that alcoholic women step out of their feminine roles into the roles of men goes back to the 19th century, Dr Fillmore notes, it is still found in research of the 1980s. Now, it is interpreted as "sex role conflict" — the difficulty women have juggling both feminine and masculine roles.

Changes in approach to the study of alcoholism over the years also slowly changed the perception of female alcoholics. In men, the Skid Row image gradually changed to a picture of the employed alcoholic. It took longer for the female image to move from prostitute to housewife hiding her drinking behind closed doors.

The emergence of household surveys allowed researchers to move away from clinical samples to the study of "normal" population groups. This forced a change in definitions. Researchers no longer looked at abstainers vs drinkers, but at "heavy" drinkers vs "social" drinkers. Heavy drinking, 1960s surveys showed, was a rare phenomenon among women. Thus, from the 1940s through the 1960s, from a research point of view, women were not a very interesting target for study.

But, while surveys suggested heavy drinking was rare among women, clinical studies increased. By 1976, the (US) National Council on Alcoholism created a special office on women and held its first national conference on women and alcoholism.

Yet, epidemiological work in the late 1970s and early 1980s, failed to bear out the claims.

Asks Dr Fillmore: If epidemiological work over 30 years indicated alcohol problems did not seem to be increasing among women, what factors in the scientific community made it possible to perpetuate the "myth" that they were? Why should society at one point minimize the problem and at another point maximize it?

She suggests the "epidemic fires" may have been allowed to burn for methodological reasons, such as a broadening of criteria and an underestimation of women alcoholics in the first place, and also because of competition among the mushrooming treatment and research agencies.

For example, alcohol problems were also seen to be increasing among other "competing interest-groups," such as youth, even though critics suggested the "problem" behavior was, in fact, well within the normal range.

Also, alcoholism treatment has become a growth industry. Dr Fillmore quotes one writer who suggests the shift to maximizing the problem coincides with "the movement's transformation from a voluntary movement to that of an interest group with investments for associating alcohol with a broad range of problems."

Dr Fillmore says one important political event for consideration of alcohol conceptualization in the US was the emergence of the National Institute on Alcohol Abuse and Alcoholism, which must compete with other bureaucratic agencies "struggling for the shrinking dollar" by selling its one product, the treatment and prevention of alcohol problems and alcoholism. Such organizations focus on a social problem and need new target groups for future growth.

If traditional sex roles give men, but not women, the liberty to drink and to get drunk, this may explain why fewer women are deviant drinkers. Or, it may be that "the exaggerated claims for deviant drinking among women actually reflect a societal reaction to any drinking among women," Dr Fillmore says.

Society is still responding to drinking by women as deviant, despite the distance from Prohibition, the public's acceptance of alcoholism as some form of a disease, and the governmental sanction for treating and preventing alcoholism.

Dr Fillmore says that data from US national surveys between 1964 and 1979 suggest younger women are beginning to engage in a pattern of drinking (although not in the same proportions) similar to that documented as putting men at risk of drinking problems.

"Older cohorts of women exhibited a drinking curve in which heavy-frequent intake is rare in youth, rises in middle age, and then drops in old age; men (in the US) have generally exhibited a drinking curve in which heavy-frequent intake is high in youth and drops in middle and old age.

"My suspicion is that younger cohorts of women, born particularly after the mid-1950s, are drinking more heavily."

College youth in general and college women in particular have increased drinking frequently, Dr Fillmore says. The earliest age of drinking has also dropped among both boys and girls "probably modestly facilitated by almost half of the individual (US) states where, between 1940 and 1980, the legal drinking age has dropped."

However, Dr Fillmore does not see an "alcoholic epidemic" on the horizon.

Fillmore: societal reaction

"Life-cycle curves we have roughly projected on women's drinking are changing as a result of historical and cohort effects. Older cohorts of women born in 'drier' years were less likely to drink during their youth; younger cohorts born in 'wetter' years are more likely to drink at younger ages."

As a result, Dr Fillmore predicts, "younger females will exhibit the peak of their drinking in their late teens and early 20s, as do males, with those rates dropping as the cohorts age."

The pivotal question for future research, she concludes, is why so few women experience problems with their drinking when subjected to the same lifestyles and life problems as male counterparts.

"Such inquiry would lay a more solid groundwork for understanding the processes that protect both men and women from excessive drinking in a culture characterized by its high and permissive use of alcohol."

THE BACK PAGE

Responsibility for national drug control policy rests with Epp: Donald Smith
p8

MDMA
p11/12

Psychotropics: reviewing the revolution
p9

Cannabis research stuck in neutral — again

By Elda Hauschildt

SASKATOON — Cannabis has not only lost its "glamor," it has also lost the interest of research funding agencies, researchers, physicians, and the public. Yet, the need remains for long-term studies on the effects of its use, says Juan Carlos Negrete, MD.

People must "start making noises" about the importance of such research now, before the subject is again dropped. And, it has been, several times, in the past 100 years, he told parents here at a PRIDE Canada (Parent Resources Institute for Drug Education) meeting.

"Concern over this drug is not in the short-term, but in the long-term effects," said Dr Negrete, director of the alcohol and drug dependence unit, Montreal General Hospital, and psychiatry professor, McGill University, Montreal.

"But, cannabis has lost its glamor. Cocaine is making all the noise now. Cannabis is no longer popular — politically significant — so there's little money available for research.

"The issue needs revival, and scientific interest and scientific work is often the result of community concern," said Dr Negrete, also a consultant on alcohol and other drugs to the World Health Organization.

He told the parents they are the right group to raise the issue of the need for longitudinal cannabis research.

It was such public concern that resulted in the first organized, scientific inquiry into cannabis use, in the 1890s, after British colonial officers became aware of marijuana use in Bengal, India. That concern resulted in the British parliament's setting up a commission to study use throughout India.

"The findings were not much different from what we know now.

"They said cannabis does not cause dramatic health consequences in the short-term. It does so only in a minority of users, who are either excessive users or individuals vulnerable to the effects of moderate amounts."

Dr Negrete: "The pity is that after such a huge amount of work, the report was shelved, and nothing followed. The suggestions were there already that you cannot complete the study of the health consequences of this drug in two years and not do any follow-through with early, active cases."

Public concern led to other public inquiries: in the Panama Canal Zone in the 1930s, in New York city in the 1940s, and across North America in the 1960s. It was in the

See Health issues, p3

1960s that "marijuana use, which had been limited to rather deviant minorities in the population . . . became a problem of the middle class and their youngsters," Dr Negrete said.

Research followed, but then stopped again.

"In 1975, in the *Index Medicus*, the registry for all medical and scientific papers presented or published, there were 287 papers listed under cannabis. Ten years later, there were only 77 papers."

In 1982, he said, the Institute of Medicine in the United States Academy of Sciences recommended, without success, prospective studies be done on cannabis use.

Vol. 15 No. 7 2nd Class Mail Reg No. 2776 TORONTO, July 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Mass appeal of rock 'n roll — does it turn kids on to drugs?
The Back Page

Psychiatrists misread women's ills

By Elda Hauschildt

GENEVA PARK, Ontario — Psychiatrists' misconceptions, both of themselves as scientists and of the biochemical nature of psychiatric disorders, often lead to misdiagnoses of women alcoholics as depression and anxiety cases.

"Psychiatrists like to think of themselves as objective and scientific, but psychiatry is more of an art form than a science," Susan Penfold, MD, told **The Journal** following a National Consultation on Women and Drugs here.

Dr Penfold is co-author of the book, *Women and the Psychiatric Paradox*. She is on leave from the school of psychiatry, Faculty of Medicine, University of British Columbia, Vancouver, to chair the new women's studies program at Simon Fraser University, Burnaby, BC.

"There are more than 200 different types of therapy, so it's a grave mistake for psychiatrists to think of themselves as scientists.

"Each individual patient must be looked at as a unique individual, subject to all her own experiences, stresses, and strengths. Psychiatrists must rely on their intuition, common sense, and experience and not think of themselves as scientists."

Dr Penfold said psychiatrists have stereotypes of women and stereotypes of alcoholics in mind and fail to diagnose women alcoholics unless the signs are so overt as not to be missed.

"Psychiatrists expect women to be depressed, not alcoholic; they expect alcoholics to stagger and get into bar-room brawls. Unless a woman patient weaves into the office or needs emergency medical care — things women alcoholics

(See **Women, p2**)

Alcohol aids only duller brethren

Creativity put to drinking test

By Alan Massam

SHEFFIELD — Alcohol can enhance creativity, but only in people who are not very creative in the first place. For those who are, alcohol impairs.

These are among the conclusions of Geoff Lowe, senior lecturer in psychology, University of Hull, in a paper presented to the annual conference of the British Psychological Society here at the University of Sheffield.

Dr Lowe reported 16 men and 16 women aged from 18 years to 30 years were given enough vodka and tonic to put them above the legal limit for driving. Then, on another occasion, they were given a water and tonic drink, with vodka smeared around the rim of the glass to give the drink the smell of the real thing.

The subjects were given standard creativity tests, with such questions as, how many uses can you think of for a cardboard box, and what if clouds were attached to the earth with strings?

Dr Lowe found the people who were creative in their answers when sober did significantly worse when drunk; those who were not so creative when they drank water improved after some vodka.

Dr Lowe is not counselling the duller brethren to take to the bottle, however. He warns that what works for one type of creativity might not work for another.

INSIDE

NEWS

Briefly ...

The 60s revisited

POWYS, Wales — Colonies of "drunken, drug-crazed, filthy, and violent" hippies are being refused all but emergency medical help here from doctors, who fear for their personal safety. The vagrants live on hills in mid-Wales, seeking hallucinogenic 'magic mushrooms' (psilocybe), says Ken Harvey, a local physician. Dr Harvey told *Doctor* some are well-educated but become violent under the influence of the mushrooms. Pregnant vagrants are also being spurned by physicians who don't want to be responsible for tragedies resulting from the drifters' living conditions.

Beer can melody

LANSING, Mich — Authentic Budweiser beer cans wired up as transistor radios and sold to kids alongside Cabbage Patch Kids and Snoopy radios enraged an Ohio health department official enough to make him complain to the manufacturers. The Tandy Corporation is now turning the volume off on "Bud" radios, selling the few left on shelves without promotion, says *Monday Morning Report*.

Yen to say no

GENEVA — The non-smoking movement is gaining momentum in Japan, especially in the workplace. An Osaka chemical company now offers a monthly bonus of 2,000 yen (Cdn $16.70) to non-smoking employees, says *Tobacco Alert*. A worker who manages to kick the habit for six months gets a 50,000 yen bonus. In two years, 80 employees have given up smoking completely.

R_x for drivers

LONDON — Doctors here have been reminded they should warn their patients in cases where prescribed medicines may influence fitness to drive. The advice comes from the British Medical Commission on Accident Prevention in a booklet being sent to all family physicians.

A rose by any name

CALGARY — A shortcut method used by two Alberta distillers to produce inexpensive liquor has some industry officials perturbed. The whisky ages in only a few days and costs about $3 less per bottle than regular whisky, says *Canadian Press*. The Association of Canadian Distillers says it wants to "protect the integrity" of Canadian whisky, and the cheaper brand should not be passed off as the "original."

Mum is the word

LONDON — British physicians concerned about their mental health or use of alcohol and other drugs can now telephone a service offering confidential help. The National Counselling and Welfare Service for Sick Doctors tries to get medical help for impaired physicians before a doctor's employers or the General Medical Council initiate formal suspension proceedings, says *Medical World News*.

Refugee addiction to opium smoking being treated in special clinic in US

By Harvey McConnell

Southeast Asians here (left) and at home (right: the only things they have are family and clan

WASHINGTON — Addiction to smoking raw opium among refugee Hmong tribesmen from the mountains of Laos is being successfully treated at a special international clinic at the University of Minnesota, Minneapolis.

A 30-day, inpatient program involving close family support, special food, methadone, and naltrexone leads to successful detoxification and has so far prevented relapses.

But, there are still questions, Anthony Troiano, MD, psychiatrist and chemical dependency fellow at the university, told **The Journal**.

"We still haven't determined yet exactly how much the raw opium costs, what is the exact amount they use, how much they smoke, and what the equivalent (potency) is."

The Hmong, few of whom speak English, claim the Chinese bring raw opium into the United States and distribute it. It appears to cost between two dollars and seven dollars for an amount of raw opium equivalent to the size of a matchhead. This is put in a pipe and smoked.

Dr Troiano, who presented a report on the results of the first six months of the program at the annual conference here of the American Psychiatric Association, said the Hmong assisted the US during the Vietnam war and have since been allowed to enter the country.

Members of the 12 Hmong clans, a distinct minority in Laos, have been relocated in various parts of the country. Some 20,000 live in the Minneapolis-St Paul area.

The Hmong have grown opium poppy for centuries but used it only to ease the effects of the many intestinal diseases endemic in Southeast Asia and to alleviate pain. On the trek from the mountains of Laos to temporary refugee camps in Thailand, many were injured and smoked opium to relieve the pain, but apparently were detoxified before they came to the US.

Dr Troiano said when Hmong started to appear at the emergency room complaining of chronic pain, diarrhea, depression, and family problems, they investigated and found some were smoking opium.

A majority of the program patients, who come by word of mouth, are unemployed, married men and women who smoked from 25 to 150 pipes a day to self-medicate pain. They had attempted to stop but resumed in order to alleviate withdrawal symptoms.

Dr Troiano: "Heroin is outside their culture completely, and they recognize only three drug groups: Aspirin (acetylsalicylic acid), antibiotics, and opium. That's it."

Apparently, the addicted Hmong will smoke opium two or three times a day in cycles of one to four hours: usually, they smoke alone.

"We have not seen opium gathering or an opium den kind of thing."

The clinic program involves a 21-day tapering-down dose of methadone. Initial dose levels are determined on clinical grounds and approximate daily use reported by the patients, their family, and friends. Seven to 10 days after methadone ceases, if a Narcan (naloxone) challenge shows no signs of withdrawal, they are put on the antagonist naltrexone.

They then enter an aftercare program where they receive naltrexone to discourage opium use and take part in specifically tailored support groups. The clinic maintains contact with appropriate social and welfare agencies.

Dr Troiano: "The Hmong maintain their culture as best they can. They have developed their own support mechanisms among their family and friends, and I doubt very much if they could maintain their recovery without it.

"I think because of the social disruption of opium they want to stop, and it makes no difference why they became addicted. The only things they have are family and their clan."

Women should reject traditional treatment

(from page 1)

are unlikely to do — the diagnosis is often missed."

Realization of the role female stereotyping has played in mental health services has brought "exciting changes in the last decade and a half," Dr Penfold said.

"Women have found many ways of dealing with, or departing from, a mental health system which all too often merely reflected society's norms and 'helped' women adjust to their place and their lot."

Her book, written with Gillian Walker in 1982, "attempted to delineate the paradoxical functions of psychiatry, to show how it is a force of social control. We tried to demonstrate its pervasive role in the preservation of society's norms, including the reinforcement of women's traditional status," she said.

"Psychiatry is both part of the ideological and coercive mechanisms of industrial society and committed to a resolution of the very tensions and strains which that society and its institutions produce."

Dr Penfold: "Psychiatry has its 'expert service model' which provides an elaborate framework for blaming the victim. It functions to locate and contain within the individual and the family unit the distress, damage, and dysfunctional aspects of society.

"Psychiatric practice has thus become the answer to many social problems and can provide a ready and convenient rationale for maintaining the status quo in society.

"From the central paradox flow many contradictions which illuminate the non-scientific and culturally based nature of the psychiatric endeavor."

Recognition of the sexist nature of the mental health system, "awareness of its social control functions, realization of the problems of labelling, and the stigma attached to the term mental patient has led many women to reject traditional services and concentrate on seeking, initiating, or supporting alternatives," Dr Penfold said.

And, rightfully, there should be continued movement by women away from traditional mental health services toward community models: self-help and support groups, networks, and systems.

"Support groups should be established in non-traditional, non-threatening settings away from hospitals or mental health clinics."

Dr Penfold told **The Journal** continued demand for change has to come from the consumer, and "this is happening: more treatment centres are available for women."

But, psychiatrists and physicians have to be made more aware of women's issues. "Women's issues are now being minimized and trivialized. A lot of community education needs to be done — within the medical profession, within the community, and with women."

The National Consultation on Women and Drugs was sponsored by the health promotion directorate, Health and Welfare Canada.

Reports from Helsinki

Washington contributing editor Harvey McConnell reports next month from the 3rd Congress of the International Society for Biomedical Research on Alcoholism.

NEWS

Health issues blur social costs of cannabis use

By Elda Hauschildt

TORONTO — Concern about the health effects of cannabis use has overridden public awareness of the social costs of each year labelling at least 20,000 young Canadians as criminals for cannabis possession, says a drug policy researcher here.

Furthermore, says Patricia Erickson, PhD, the authority of the criminal law is demoted simply because the system can so efficiently process that many convictions annually.

Dr Erickson says at least 20,000 Canadians under the age of 25 years have been processed as cannabis offenders each year since the numbers began rising in the early 1970s.

But, because health concerns have dominated public discussion on cannabis, one pressure for reform of cannabis laws — the worry that such criminal records may affect young people for life — has been removed.

"It doesn't make sense to me that concern for the health of young people should be expressed by saddling them with lifelong criminal records. It doesn't go with having their best interests at heart," Dr Erickson, head of drug policy research at the Addiction Research Foundation here, told **The Journal**.

"Nevertheless, if one takes a view that's at all critical (of the concentration on health concerns), one tends to be labelled as someone who isn't interested in the health of young people."

But, she adds, health is "suffering anyway. The law hasn't eliminated that — cannabis is here, and it is being used."

Cannabis convictions began to rise dramatically in 1970: to 5,419 convictions compared to 2,313 in 1969. By 1973, the total was up to 18,603. In every year since — including 1984, the last year for which statistics are available — at least 20,000 young Canadians have been convicted.

"When you use a criminal law that widely, you devaluate that law," says Dr Erickson. "You trivialize it, demoting its authority."

Cannabis law wasn't introduced because of health concerns. she says, but people have "transformed it into a health message" by making use of research data on the drug's health effects.

Dr Erickson believes there is no evidence to show the law is successful in transmitting a health message. "It's successful in transmitting the notion we're going to punish you if you do this."

However, health concerns are getting through anyway, she says. "There is a gradual accumulation of awareness that the use of a lot of cannabis for a long time isn't a good thing. The message is getting out that a drug is a drug, and cannabis is a drug."

Wanting cannabis law liberalized "doesn't mean you deny the health risks, or approve of cannabis use, but that you think there are better ways of dealing with the problem."

Dr Erickson, with research associate Glenn Murray, compared cannabis convictions in 1981 in Toronto with similar convictions here in 1971, looking at personal and legal characteristics of offenders, individual costs of conviction, and administrative practices.

They found the background and drug use characteristics of offenders were similar in both time periods — young, single males who used cannabis twice a week or more, pleading guilty to possession of small amounts of the drug (14 grams or less in 75% of the cases).

The main difference was in the quicker response of the criminal law system in 1981, both by police and courts. And, the offenders themselves speeded up the process by doing without legal representation more often: 65% weren't represented by counsel in 1981, compared to 41% in 1974.

Offenders viewed their convictions casually. "They're so unaware of the impact of the law, partly because they haven't had lawyers and don't understand what their convictions mean," Dr Erickson says.

The study shows few offenders see themselves as having done something criminal; 4% in 1981, compared with 6% in 1974, and few consider friends see them as criminals. There was little social stigmatization in either time period.

Erickson: pressure removed

"If enough of them go off with clear consciences, then that changes the meaning of the law. If enough people feel that way, that's the reality, not what the law says," concludes Dr Erickson.

Problems of women with addictions critical

Non-sexist research first step to improving treatment

By Elda Hauschildt

GENEVA PARK, Ontario — Non-sexist research is needed in Canada in response to the "pressing problems of women and addictions," says the president of the Canadian Advisory Council on the Status of Women.

"And, I tell you most emphatically that I see little evidence of investment in research and development which could lead to improved treatment and prevention of substance abuse by women," Sylvia Gold told the National Consultation on Women and Drugs here.

"Statistics we do have clearly point out the vulnerability of women to mental illness, to drug abuse, and to physical danger. Coincidentally, they indicate our invisibility in the structures of decision-making, where actions in these areas are taken."

Ms Gold defined non-sexist research as research "that takes gender into account in all aspects of the research process: conception of the problem, design, research questions, theoretical frameworks, methodologies, interpretation of results, evaluation, and recommendations for policy.

"Primary data is collected and broken down by sex."

Non-sexist research takes a balanced approach, "using language and concepts which reflect the current reality and incorporate female and male experiences," Ms Gold said.

Gold: the reality gap

She quoted a 1985 study by the American Psychological Association (APA) in the United States, which reported that although women with alcohol problems show different patterns and characteristics than men, most major alcohol studies use male samples.

The APA study also pointed out alcoholic women are more likely than men to use other drugs along with alcohol, yet studies of patterns and incidence of drug abuse in alcoholism are rare.

Ms Gold said she was "more and more preoccupied by the absence of consideration of the peculiarities of women's lives, aspirations, and realities" in public policy, research, education, program delivery, and professional training.

Given the "invisibility" of women in decision-making in such areas, she said, "it's no surprise that much of our research money is devoted to heart and cardiovascular disease, the diseases of the 'typical' breadwinner.

"But, little or, in many cases, nothing is devoted to health issues of primordial importance to women, to do with our mental, social, and physical well-being."

Ms Gold said another problem women face is the "reality gap" between institutions and the "reality" of women's lives.

"I would caution you against assuming that the numbers show the whole picture. We must always get into the story of a woman's life before we can begin to understand her motives and the stresses she lives . . . . We must insist that our treatment and care of women is informed by women's experiences."

The National Consultation on Women and Drugs was sponsored by the health promotion directorate, Health and Welfare Canada.

INSIDE OUT

A new game with harder rules

I saw him from away across the room and knew what had happened.

I didn't have to get close to him to see the panic blotches on his neck or the desperation in his eyes or to hear the curses exploding from deep inside the well of his frustration, as he held on tightly to the back of his chair.

There was an inevitability to this event on this late afternoon, the type that the ancient Greek dramatists had been uncannily aware of: the alarm clock of fate had gone off just the way it was meant to do. It was too late now to stop the ringing.

My friend's sister had just been arrested for trafficking in cocaine, and, although my immediate concern focused on his pain and rage and not her plight, a cooler part of me kept saying: it had to happen this way, we knew it was going to happen, even she probably knew it was going to happen. It's over, her life has changed irrevocably, and the entire game will have new, harder rules for her.

Later in the evening, in the police station and the coffee shop across the street from the police station, and at the well-decorated, downtown lawyer's office discussing what should be done about getting her some kind of rehabilitation before she had to face the court's justice, and on the street afterwards when my friend finally had to go and face his parents at their home and tell them the truth about the extraordinary day, I continued to think the same thing. It was this: addiction has one tough, bitter, ironic, unchanging truth to it.

We have to quit, those of us who are wired to whatever our drug of choice is, because we can't stop.

The alarm clock of fate had gone off . . . it was too late to stop the ringing

And for those of us who have realized just what that means and the brutal price to be paid for the understanding of it, it becomes like a Zen *koan* that only the addicted can truly comprehend: *We have to quit, because we can't stop. We have to stop, because we can't quit.*

My friend's sister had been plugged into the North American Cocaine Electrical Utility for a long time. His worrying had increased in the last few months; he became distracted, couldn't sleep; he was being consumed.

I watched him go through the paces: denial, anger, impatience, a continuing sensation of impotence, of approaching doom, futile hoping that a small miracle would happen. Up, down, up, and down on the rollercoaster known to anyone who's ever had any dealings with and concern for someone with a loving relationship with an addict.

So my friend cajoled his sister, he threatened her, he did everything possible to protect her. He followed her around. He pleaded with her 'main man' dealer.

He asked me to talk to her. I said yes. He had seen my own struggles, had been there when it counted. But, then, it would all quiet down a little; the urgency of his requests would diminish.

Then, again, he'd ask me. I'd say yes, knowing of course, that very rarely is friendly advice, or even a heavy warning, of any palpable use to someone who's wired. It's a play where the last scene is always known beforehand, like a romance novel with its happy ending turned inside out to reveal a horror show. And then, life would go on, for my friend and his sister and I, stumbling along its circuitous paths. And then it would be all shunted aside.

And, again, he'd ask me . . . .

Finally, I did call. My friend's worrying had reached a climax. His sister had taken to disappearing; he'd found drugs — a big quantity — where she was living.

She knew a little about what I had gone through, with alcohol. There was no reason, I told her, to feel paranoid about me; I'd been there, I'd crossed that gap separating addictive people from the lucky hordes who weren't. Was there anything I could do? Did she want to talk about what was going on? Did she want any help?

She was pleasant and civil. We had known each other, after all, only superficially.

Yes, she said, she'd call me. Maybe. In case she suddenly needed to talk. But, she was okay, really. She was in control. No problem. Call me, I screamed inside myself and, to her, said: call me.

But, the clock was ticking, relentlessly.

A few days later, they came to get her. They took her down. They took the 'main man' down.

They took a world down, too, a world based on deception and denials, on false hopes, pie-in-the-sky fantasies.

A world that had to be taken down, I think my friend is telling himself these days. It had to end the way it did, and I think he knows that now.

We have to quit because we can't stop. We have to stop because we can't quit.

It's so obvious, so simple, so plain, so — almost — facetious.

It only took me 20 years to figure out what it means.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Hair loss a cocaine clue

Loss of eyebrows or eyelashes (madarosis) has been identified as a possible marker for cocaine abuse. Two New York physicians have reported the case of a 17-year-old patient with AIDS-related complex who had bilateral loss of eyebrow and eyelash hair without any accompanying hair loss or facial rash. Drs Steven Tames and John Goldenring of the New York Medical College, Valhalla, said questioning revealed the patient had recently made increasing use of crack, a freebase form of the drug, which is placed in a glass pipe, ignited, and inhaled into the lungs (**The Journal**, December, 1985). They said it appears the hot cocaine vapors rising rapidly from the pipe can singe the eyebrows and eyelashes leading to madarosis. When the patient stopped using the drug, the hair began to regrow. The doctors conclude madarosis should join chronic rhinitis and perforation of the nasal septum as "symptoms that should make alert clinicians think of cocaine abuse."

The New England Journal of Medicine, May 15, 1986, v.314:1324.

Another sour note on heroin

Juice from plastic lemons is the probable source of an infection which struck a group of Scottish heroin addicts. Candidal endophthalmitis, an eye infection that can cause blindness, was diagnosed in a group of 23 heroin addicts between November, 1982 and August, 1985 in Glasgow. Investigators from the medical mycology unit, University of Glasgow dermatology department, and the Tennent Institute of Ophthalmology there, evaluated possible sources of the infection. They found 22 of the heroin addicts had used lemon juice from plastic lemons as a drug-diluting agent. Two of the lemons available for testing yielded pure, heavy growths of *Candida albicans*, one of the contaminants that can cause the infection. The researchers note that while juice from fresh lemons has been suggested as a possible reservoir for candidal infection, their study also suggests juice from old plastic lemons, from which the preservative, sulphur dioxide, has evaporated, can also become contaminated with C albicans. While they were unable to analyze the heroin itself, it was less likely to be a source of infection because diacetylmorphine is fungicidal for C albicans. The report concludes the risk of fungal endophthalmitis is an additional risk of heroin addiction that should be made more widely known "as a disincentive to tentative abusers."

British Medical Journal, April 26, 1986, v.292:1106-1107.

Lung damage from pot evaluated

Strong evidence that heavy marijuana smoking, especially when combined with tobacco use, damages the gas exchange surface of the lung, has been reported by Massachusetts researchers. Physicians from three medical centres in Boston and Belmont investigated the effects of chronic marijuana smoking on lung function by measuring pulmonary function in 15 healthy women who habitually smoked marijuana almost daily for from three to 16 years. Their results were compared with those from groups of 27 non-smoking and 26 tobacco-smoking women. Testing revealed marijuana smoking, with or without tobacco use, was associated with a reduction in the single-breath carbon monoxide diffusing capacity of 74% of the predicted value. This was significantly different from that of the non-smoking controls who had a capacity 92% of the predicted value. Those subjects who smoked marijuana and tobacco had a further reduction in capacity to 65%, which placed them significantly below even the group of tobacco smokers. Results suggest "a major effect of marijuana when added to tobacco smoking in damaging the gas exchange surface of the lung as measured by a decline in the single-breath carbon monoxide diffusing capacity." The effect of two marijuana cigarettes per day in damaging the gas exchange surface appears comparable to smoking one pack of cigarettes a day.

The American Journal of Medicine, April, 1986, v.80:601-604.

Solvent abstention clears CNS

Persistent neurological problems caused by chronic solvent abuse have been detailed by three Denver physicians. Noting previous reports concentrated on the acute effects of inhaling toluene-based products such as spray paint, glue, or paint thinner, researchers from the neurology department, University of Colorado School of Medicine, Boulder, Colorado, studied 16 men and four women with a history of chronic solvent vapor abuse. Mean duration of abuse was 12 years, although the subjects had abstained from intoxicants for at least four weeks prior to neurologic examinations undertaken as part of the study. The researchers found some neurologic impairment in 13 of the 20 patients (65%), while 12 patients (60%) also had cognitive dysfunction. Seven of the 12 were disabled because of dementia. A specific pattern of apathy, poor concentration, memory loss, and visuospatial dysfunction was seen with these subjects. Neurological abnormalities included tremor, poor coordination, spasticity, hyperactive tendon reflexes, and disorders of eye movement, hearing, and sense of smell. Computed tomography showed atrophy of various parts of the brain in eight of the nine subjects evaluated in this way. The report states continued improvement was observed in five patients who remained abstinent for six or more months, suggesting that improvement is possible after the solvent is cleared from the central nervous system (CNS).

Neurology, May, 1986, v.36: 698-702.

Pat Rich

Immune system responses confuse data on cannabis

By Harvey McConnell

WASHINGTON — The highly variable nature of marijuana's influence on the immune system is a major reason for conflicting data produced in the last decade.

Long-term research at the College of Medicine, University of South Florida, Tampa, shows that enhancement, suppression, or lack of effect on a particular resistance mechanism depends on the cannabinoid dose, time of administration, and extent of metabolism of delta-nine tetrahydrocannabinol (THC) to other compounds.

Herman Friedman, PhD, chairman of the department of medical microbiology and immunology, told an Alcohol, Drug Abuse and Mental Health Administration symposium here marijuana contains a large number of biologically active substances, including more than 50 cannabinoids and non-cannabinoid compounds.

Because of variance in responses to marijuana, he has concentrated his research in animals and humans on the effect of purified cannabinoid components on several immune phenomena.

He has found THC suppresses the function of both B and T lymphocytes, cells important in activation of the immune response. As well, THC suppresses production of interferons by lymphoid cells, an important part of maintaining a healthy immune system.

Both peritoneal and splenic macrophage function is suppressed by marijuana components, and this can also compromise the resistance mechanism.

Dr Friedman found in tests of cultured human natural killer cells, which play an important role in the defence mechanism against malignant and viral cells, that THC readily suppresses killing ability for a short time after exposure.

The variability of THC has been demonstrated with antibody production: low doses appear to enhance antibody production, and higher doses suppress it.

Friedman: conflicting data

Experiments in mice demonstrate acute administration of THC followed by sublethal infection with *Legionella pneumophilia* or *Streptococous pneumoniae* results in increased mortality, while chronic injection of THC does not alter susceptibility to the infections.

Ontario group becoming vocal

Docs take on tobacco marketers

By Terri Etherington

TORONTO — A growing number of Ontario physicians are becoming vocal in their efforts to counteract the marketing efforts of tobacco manufacturers, says a spokesman for the newly formed Toronto chapter of Physicians for a Smoke-Free Canada.

Jack Micay, MD, an emergency room physician at Northwestern Hospital here, says doctors have to deal with the consequences of the smoking epidemic. "There is no other area in all of medicine that would be as fruitful in terms of prevention.

"It is frustrating and futile to try to get people to stop smoking," Dr Micay told **The Journal**. "It doesn't work at all. The key is prevention of the addiction in the first place, and the key to the spread of this addiction is promotion.

"Here is a dangerous drug that is not only legal, but is the most advertised product in our society" (**The Journal**, May).

Arthur Chesterfield-Evans, MD, one of the founders of the original physicians' group in Australia, (**The Journal**, November, 1983) urged 20 physicians at the first meeting of the Toronto group to become more vocal, public, political, and militant to combat the marketing efforts of the cigarette manufacturers.

A steering committee has been formed to plan a local strategy. Dr Micay said the Toronto chapter will likely direct its energies to political lobbying, relying on the credibility of the medical profession to add weight to their arguments.

Physicians for a Smoke-Free Canada was established two years ago by Andrew Pipe, MD, Ottawa (**The Journal**, June) and now has approximately 600 members.

Drunk boaters given notice

ANNAPOLIS, Maryland — A drive to reduce the number of accidents by drunk boat users is to be launched by the state of Maryland.

A model program is being carried out by state authorities for the United States National Institute on Alcohol Abuse and Alcoholism.

Maryland governor Harry Hughes said the beer and boating industries will take part in the program aimed at increasing public awareness of the problem.

Maryland officials report 194 boating accidents in 1985, causing 17 deaths. Alcohol was involved in 85% of the cases.

In the volcano: carver Albert Te Pou with message

Maori carving to clear the air

AUCKLAND, NZ — Thrust your tongue into a volcano and you're liable to fall in, that's part of an anti-smoking message delivered by a Maori carving in a doctor's consulting room in a small town here on the North Island.

The other half of the carving's message is more positive; non-smokers are the ones who prevail and are able to hold on to the sun, which represents life.

A local family doctor, John Roper, decided to employ a traditional approach to discourage smoking among the predominantly Maori population in Murupara.

Use of the carving, Dr Roper says, sprang from his concern about people destroying their health by smoking. Maoris have a higher smoking rate than Europeans in New Zealand, and Maori women have the highest incidence of lung cancer among women in the world

"I don't believe all this propaganda of great notices saying 'Don't smoke,' " says Dr Roper, the town's only doctor.

"No one ever changed their attitude because of that. I thought we would combine the thing (prevention) and have a nice carving."

NEWS

Most parents of users totally unsuspecting

Kids on drugs regularly outwit professionals

By Harvey McConnell

WASHINGTON — Young cocaine and marijuana abusers are adept at fooling mental health professionals, including psychiatrists, about their drug use.

A study of white, upper middle-class adolescents in suburban Springfield, Virginia shows 66% of heavy cocaine abusers and chronic marijuana abusers, who do not use cocaine, easily fool professionals.

"And, we found that 25% of the cocaine abusers, referred for family or school problems, actually went to psychiatrists and other mental health professionals while high and were not detected," Richard Schwartz, MD, clinical professor of pediatrics, Georgetown University School of Medicine here, told The Journal.

"It is not rare. They do it just to play head games with the psychiatrists, as a way of achieving superiority. Rarely are drug screens done."

Dr Schwartz said he began his study two years ago in collaboration with Mark Gold, MD, and colleagues at Fair Oaks Hospital, Summit, New Jersey (**The Journal**, December, 1985), because there are few data on the impact of cocaine on adolescents. He presented preliminary findings at the annual conference here of the American Psychiatric Association.

Dr Schwartz said his investigation focused on 20 cocaine abusers aged 14 to 17 years, who had used the drug at least 50 times, with a median of three times a week. They were compared to 20 matched controls, daily marijuana users with a median of 1.25 years use, but who had never used cocaine.

Schwartz: head games

The findings indicate 45% of the cocaine abusers and 25% of the marijuana abusers had at least one brain seizure.

Dr Schwartz said the adolescents came from families where 55% of the fathers were college graduates — "children of a high-achieving, middle-class population." At least 75% of the parents did not suspect their children had drug problems for at least one year of frequent drug use.

Cocaine abusers got drug money from "working, allowances, stealing, and dealing." Four 15-year-old girls turned to prostitution "not on a daily basis, but enough to supply their drug needs."

Dr Schwartz said in such cases when the parents find out about the drug problem, "they know but they don't know everything, and maybe it's just as well."

Other findings are that 80% of the cocaine abusers were marijuana-dependent and the time span of first use of cocaine to weekly use averaged 1.3 months for 50% of the group. When compared with the marijuana group, the cocaine group had higher rates of school suspension (38% vs 22%) and truancy (75% vs 55%).

Most of the cocaine abusers inhaled the drug. While 40% said they had tried freebasing, only about 12% did it as a rule.

Because it's rare for adolescents to admit freely to drug use, Dr Schwartz has also been collecting informal data through an anonymous questionnaire for patients in his private pediatric practice.

"I have found so far that 16% of my middle-class, pediatric kids, who are all doing well and are not in treatment or anything, have had experience with cocaine," he said.

Teachers, community workers strive for ways to help

By Terri Etherington

TORONTO — For educators and community service workers, the message is simple: We're all in this together.

But, solutions to the problem of alcohol and other drug abuse by young people are less clear, the two groups agreed here at a seminar.

Guy Matte, president of the Ontario Teachers' Federation (OTF), said concerns shared by many teachers were outlined in a brief from the OTF to the Ontario government. "The public wants the schools to correct the manners and morals of today's youth." Yet, many of these problems "are the result of factors over which schools have virtually no control.

"The best efforts of teachers are wasted on minds impaired by drugs and alcohol. The apparent failure of education programs . . . confirms the inability of the school alone to counteract these problems created in the larger society," Mr Matte said.

Joan Marshman, PhD, president of the Addiction Research Foundation (ARF) here, reviewed recent Ontario student survey results (**The Journal**, December, 1985) which show "fewer kids are using drugs, but the users are using just as much as they always used."

Dr Marshman: "This suggests that we might have had some impact through various community efforts — efforts of schools, of parents, of various other parts of the community — in helping kids make the decision to stay on the non-use side of the continuum.

"We have a problem; but at least we are able to measure the size and shape of it," she said.

Michael Goodstadt, PhD, head of ARF education research, said teachers should remember there are three different student target groups: non-users, those who tried and quit, and current users.

Surveys show distinct characteristics for each group; different motivations for either using or not using drugs, and different levels of academic achievement.

The challenge for schools is to recognize students potentially at risk and to develop interventions aimed at low achievers.

Student drug-use surveys show a close correlation between leisure activities and drug use by young people. "This suggests the value of collaboration between school, family, and the community," Dr Goodstadt said.

"We've got to decide who is going to do what, when, to whom, and with what effect."

The "who" could be teachers alone, or in concert with families and other community groups.

"What are they going to do? This is one of the places where the people in the education profession have the strongest input: deciding what is the content, the process, the strategies, the form of our intervention," he said.

"When are we going to do it? There are points in the developmental stage of the child that we, as educators, know are opportune moments to intervene."

To whom, means deciding which target groups to focus on: deciding between different groups of students or even parents.

Marshman: help kids decide

Goodstadt: opportune moments

And, "with what effect" means determining what knowledge, what attitudes and values you are going to try to influence, what skills you are going to try to develop, what behaviors you are going to try to influence, he said.

The seminar was sponsored by the ARF, the OTF, the Ontario Association of Education Administration Officials, and the Ontario Council for Leadership in Educational Administration.

HOWELL

CRTC to hear tiddlywinks jock

My dearest Nephew:

I have perused your latest missive with interest. Once again, I am flattered that you turn to me for guidance in the ways of the world. Would that I were Lord Chesterfield, and would that I were capable of responding to your letters with the kind of wit and wisdom that made his letters to his son so famous. Alas, I do not possess his easy grace with language, notwithstanding that for all my stylistic infelicities, I can still knock off a decent sentence in the subjunctive mood (witness the last one), when I put my mind to it.

But, I digress. Who cares about The Fall of the Subjunctive Mood, when all of us are faced with Nuclear Winter? But, I digress again. Let us talk about the really important things in life, such as your recent submission to the Canadian Radio-television and Telecommunications Commission (CRTC).

As I understand your brief, you are attempting to make common cause with Angelo Mosca, Boom-Boom Geoffrion, Henri Richard, Peter Dalla Riva, and George Chuvalo. You are trying to convince the CRTC the move to outlaw old 'jocks' from beer commercials is a violation of your civil rights and your right to make a living in a democratic society.

Although it is painful for me to say it, dear nephew, your status as a former North American tiddlywinks champ is not such as to likely cause brewers and ad agencies to beat a path to your door, notwithstanding that you were champ three years running.

In other words, I do not perceive your market value as an old jock to approach remotely that of such luminaries as Billy Martin or Alex Karras.

As one who has followed your career with consuming interest and was reduced to a state of apoplexy when you made that crucial chip in the 1971 Chicago tournament, I can only bemoan the fact the major networks have failed to appreciate the drama and excitement of international tiddlywinks and have perversely denied it a mass, Sunday-afternoon television audience. But, who knows. Perhaps your time will come.

You ask if your cause is morally just. Of course it is. Who could doubt that for a moment?

If society, in its infinite wisdom, has decided old jocks are, by virtue of reputation and experience, qualified to instruct the public on the respective merits of half-ton trucks, garden tools, barbecue devices, and woodworking equipment, it verges on the irrational to suggest they should not be instructing the public on the virtues of various brews, all the more so when one considers the public needs all the help it can get in this regard, given the gustatory homogenicity of the available products.

Given this uniformity of taste, it takes an old jock to point the way.

In this regard, I note everyone appearing before the CRTC hearings — brewers, broadcasters, and other interested parties — agreed it would be wrong to have young jocks like Wayne Gretzky selling suds on television. Of course it would. Let the young pups stick to flogging jeans and carbonated soft-drinks. It takes the seasoning of a life in sport to qualify one to comment on the subtle distinctions between one brew and another and to instruct the public on the fine discriminations only an old jock's palate is capable of making.

As far as I'm concerned, old jocks have a moral duty to share their hard-won experience with their fellow man.

Suppose, through your life in sport, you discovered you had a special ability with regard to small, ringed pastries. Would it be morally right to hide this candle under a bushel? I think not; better to create a chain of doughnut emporiums in the manner of Tim Horton.

Suppose, through your life in sport, you discovered secrets of dry-cleaning that were not generally known. Would it be morally right to go to the grave with those secrets undivulged? Obviously not; it is a far far better thing to open a chain of dry-cleaning establishments *a la* Arnold Palmer and share your unique knowledge with the common run of humanity.

Although it is unlikely an ad agency will call on you to share your special knowledge with the world, given the criminal inattention that the mass media have demonstrated toward the sport of tiddlywinks, you should be prepared for the call in any event.

It is not improbable; I've just observed young jocks from sports almost as obscure as yours flogging provincial lottery tickets on my television screen.

And so, if the call does come, dear nephew, let me give you this bit of advice. Do not confess, as you did to me, that you do not drink beer and therefore have no brand preference whatsoever. Remember that you are an old jock; remember your status in the community and the responsibilities that go with that status.

And rest assured, any brewery agent who has the prescience and superior intelligence to recognize your unique talents must, perforce, produce a superior brew — one you can endorse with all your heart, without hesitation.

In other words, take the first offer you can get.

Your loving Uncle

By Wayne Howell

NEWS

Avram Goldstein, 1986 Sidney Cohen lecturer

On the horizon — medical insight into addictions

By Terri Etherington

LOS ANGELES — The next decade or two should see exciting developments in the field of neuroscience and addictions, predicts Avram Goldstein, MD.

Dr Goldstein, professor of pharmacology at Stanford University, Stanford, California, says "researchers can now begin to hope for understanding that will give us medical insight into the causes and mechanisms of the addictions."

Such knowledge, he said, may open the way for methods of prevention and treatment hardly imagined today.

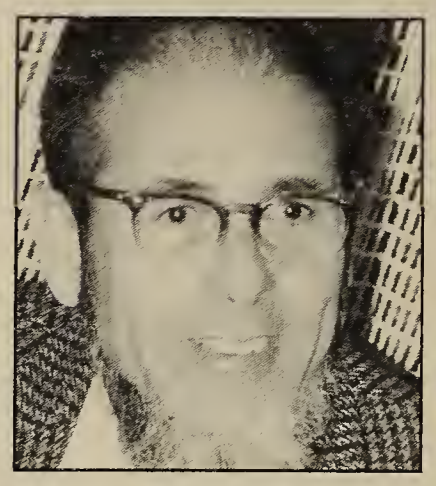
"Tests for genetic vulnerability to addiction, so prevention measures can be focused on those who would benefit most? Stimulation of the production of endogenous brain chemicals? Repair of genetic defects in peptide or receptor production? Immunizations? Long-term replacement therapies? Who knows?"

Dr Goldstein was presenting the 1986 Sidney Cohen Lecture in drug abuse medicine sponsored by the Institute for Studies of Destructive Behaviors and the Suicide Prevention Center here.

Recent developments in the study of brain chemistry and addictions show "the aim of modern research on addiction is to discover which sites in the brain, which pathways, and which of the dozens of known neurotransmitters and neuromodulators mediate the addictive behavior."

Studies with nicotine, for example, have shown the drug mimics the actions of acetylcholine, a natural substance of physiological importance in the brain.

And, recent research has focused on locating the 'reward system' in the brain. "Such studies on the reward system may help to uncover common elements that underlie the addictions, as well as to reveal anatomic and chemical reasons for the distinct differences among addicting drugs."



Goldstein: begin to hope

Linkletter: institute award

Studies similar to twin studies on alcohol should be done for those addicted to nicotine or caffeine, drugs not complicated by illegal status, Dr Goldstein said. This would help explain why "of all people who have an opportunity to become compulsive users (of any addicting drug), only a small fraction actually do.

"The first experience with many of these drugs is so aversive . . . that many people never try again. One has to speculate that *something* is different about those who not only try again, but then continue to use the drug repeatedly and compulsively," he said.

Dr Goldstein, who is also director of the Addiction Research Foundation here (Los Angeles), has received worldwide recognition for his discoveries of stereospecific opiate binding to brain membrane, in 1971, and of dynorphin (a gene encoding one of three opiate peptides) in 1979.

Art Linkletter, a United States television celebrity and drug abuse lecturer, received the 1986 US National Drug Abuse Medicine Award, presented by the Institute at the same meeting. Mr Linkletter, a media personality for more than 45 years, has served on the President's National Advisory Council on Drug Abuse Prevention and was president of the US National Coordinating Council on Drug Abuse Education and Information.

Alcohol moderation messages a 'subtle con'

MONCTON — Advertisers' messages which advocate moderation are "a subtle way of conning the public," says G. Everett Chalmers, MD, chairman of the New Brunswick Alcoholism and Drug Dependency Commission (ADDC).

He told the Moncton Mortgage Lenders' Association that while some credit could be given to those companies which allude to the value of moderation and judgement in drinking, "in the context of a real person's life, they are simply drowned out by the thousands of standard commercials, ads, billboards, and other forms of alcohol promotional activity."

He quoted from a 1984 Cleveland State University study on drinking attitudes and habits in relation to exposure to alcohol advertising among people aged 12 to 22 years. Results showed advertising "stimulates consumption levels, which, in turn, lead to heavy drinking and, worst of all, drinking in hazardous situations such as playing sports and driving motor vehicles."

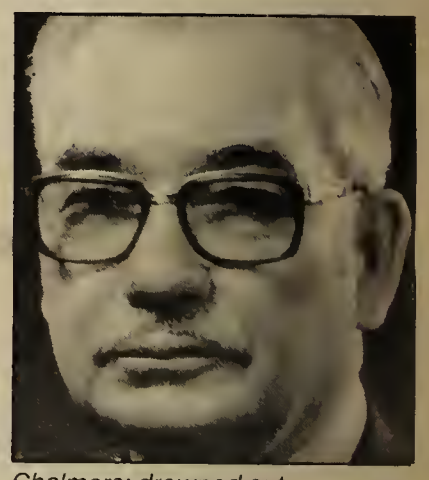
Dr Chalmers said that while alcohol has become an integral part of the social fabric, the consequences are devastating to the family, the community, and the government.

"How in the world can we, as intelligent professionals, believe that alcohol is harmless to our health? Do we still remain unconvinced that all these alcohol-related tragedies have nothing to do with alcohol consumption, easy availability, aggressive and sophisticated advertising, attractive packaging, and super salesmanship?"

He suggested an initial step of examining personal attitudes to alcohol and other drug use, looking at lifestyle, family relationships, and relationships with one's children.

"We can at least control our own lifestyles and help those with whom we are associated in the community," Dr Chalmers said, urging pressure on government for more research, education, and planning, and the development of more cost-efficient methods to deal with the problem.

The ADDC chairman urged "every parent, every community, and every professional to take a stand, not only against alcohol and other drug abuse, but also against movies, television, radio, and all advertising that sensationalize or glamorize alcohol, other drugs, and violence."



Chalmers: drowned out

Musical plays star role in anti-drug plan for kids

On stage: ways of preventing abuse, set to music

FREDERICTON — The New Brunswick Alcohol and Drug Dependency Commission (ADDC) has turned to the stage to carry to young people its message about the dangers of alcohol and other drug abuse.

The 50-minute Theatre New Brunswick Young Company production *Buzzed* premiered last December and then toured provincial junior and senior high schools. The play — sponsored by the ADDC — can be performed in either English or French and thus will reach all segments of New Brunswick's population.

The production provides a musical look at alcohol abuse and ways of preventing it. At the premiere, ADDC Chairman Everett Chalmers, MD, said he hoped the play would make people "more aware of the complexities, the dangers, and the devastating effects of alcohol and drug misuse and abuse."

Teen drug abusers offered options in weekly lifestyle attitude program

SAINT JOHN — New Brunswick's first adolescent program is available to chemically dependent adolescents here at the Ridgewood Treatment and Rehabilitation Centre.

The Alternatives programs is open to people between 15 and 19 years whose alcohol or other drug use is having negative effects on one or more areas of their lives.

It began last October under the guidance of Frank Foster, a group worker, and Bonnie Buck, head nurse.

Participants are helped to understand, recognize, and accept their chemical dependency in order to lead a drug-free life. Such factors as lifestyle, attitudes affecting dependency and sobriety, peer pressure, self-esteem, assertiveness training, creative leisure, and utilization of family and community supports are discussed at weekly meetings held during a 10-week period.

Abstinence vital in first trimester

Mothers-to-be rewarned on FAS

STOCKHOLM — Although physicians routinely recommend that women stop drinking before conception, or at least soon afterward, to avoid the danger of fetal alcohol syndrome (FAS) in their newborn, a new study here suggests the deadline may be safely extended to during the first trimester.

Investigators at the Karolinska Institute found even heavy drinkers who stopped or cut back on their intake during this period bore children without any manifestations of FAS.

But after the first trimester, moderating or stopping drinking altogether had no effect on reducing the risk of FAS, Drs G. Larsson, A-B. Bohlin, and R. Tunell reported in *Archives of Disease in Childhood* (1985; 60:316-321).

At birth, then at two-year follow-up, they assessed the physical and psychological development of 40 infants whose mothers had consumed various amounts of alcohol during pregnancy and compared them with 40 control infants. Children were grouped into three categories according to their mothers' alcohol intake during pregnancy.

All of the mothers attended an antenatal clinic and reductions in alcohol consumption reported by them were verified by checking records of social welfare authorities, psychiatric clinics, and the outpatient unit for alcoholics.

Of the heavy drinkers, 25 had an average intake of 30 grams to 125 g of pure alcohol daily, and 15 were abusers or alcoholics with an average intake of 125 g daily. Control drinkers drank less than 30 g daily.

All of the heavy drinkers but not abusers said they reduced their intake after the first clinic visit, with 19 abstaining. Nine of the alcoholic women said they stopped during the first or second trimester, but six continued to drink throughout pregnancy.

The researchers found:

- FAS was evident in half of the babies whose mothers drank heavily during pregnancy, and their intrauterine growth was severely retarded;
- babies whose mothers had stopped drinking or moderated their intake during the first trimester showed none of these effects and were apparently normal; and,
- those mothers considered excessive drinkers but not abusers, who reduced their alcohol intake during the first trimester, bore children who did not differ from the controls in physical development or behavior.

Palm sap hurting Nigerians

TEL AVIV — Widespread abuse of distilled palm tree sap is leading many Nigerians to ruin, says a researcher.

M. J. Akpaffiong, MD, department of pharmacology and pathology, college of medical sciences, University of Calabar, Nigeria, says the use of "palm wine" and "palm gin" leads to crime, broken marriages, low work productivity, and traffic accidents.

(Palm wine has an alcohol content of between 9% and 12%. When distilled several times, it is called palm gin and has an estimated alcohol content of 60%.)

Dr Akpaffiong told the 1st World Congress on Drugs and Alcohol here: "In Nigeria, the wine and gin are freely available. You can park your car, and roadside pedlars will sell you a bottle.

"In the universities, students have palm-wine drinking clubs, something akin to the oft-described student beer-drinking societies in German universities."

He added that Nigerian "quacks" often prescribe the distilled sap for many medicinal purposes, including the treatment of cancer.

"And, many use it in remedies handed down in families by grandmothers. Forty out of every 100 (people) who drink palm wine or gin daily for 15 years become lifelong addicts," Dr Akpaffiong concluded.

NEWS AND COMMENT

WHO welcomes decision on passive smoking

By Thomas Land

GENEVA — The United Nations World Health Organization (WHO) has welcomed a landmark appeal court decision in Sweden awarding industrial compensation to the survivors of a lung cancer victim who worked in a smoke-filled environment.

The organization's World Health Assembly, the most powerful decision-making body in the sphere of health and medicine, has just concluded its deliberations here in global accord about the need "to combat the tobacco pandemic."

A resolution placed before the assembly by the WHO's executive board had argued, in part, "passive, enforced, or involuntary smoking violates the right to health of the non-smoker, who must be protected against this noxious form of environmental pollution."

That was the essence also of the decision by Sweden's Insurance Court of Appeal, pronounced four years after the death of the victim, that "this case of lung cancer can be classified as an occupational injury due to passive smoking in the workplace."

A specialist spokesman for the WHO: "The case is likely to influence attitudes to smoking in the workplace not only in Sweden, but also in many countries."

And, a recent issue of *World Health*, the journal of the WHO, quotes Lars M. Ramstorm, MD, director of Sweden's National Smoking and Health Association, as concluding the decision "will support and accelerate future development toward reducing the social acceptability of smoking, and effectively contribute to strengthening measures to create smoke-free environments."

The case was brought by the family of a lung cancer victim, a non-smoker who had worked between 1962 and 1981 in a smoke-polluted, poorly ventilated Stockholm office. Her tumor was diagnosed in 1980, and she died two years later. Under Swedish employment law, a disease can be classified as an occupational injury if the victim has been exposed at the workplace to agents known to cause such ailments and if there is no major evidence to the contrary.

Because of the enormous medical, commercial, and social implications involved in the case, it was fought all the way from a regional court to the highest specialized judicial authority in Sweden. Four distinguished medical scientists testified passive smoking is sufficient to induce biological effects leading to impaired lung function.

Workplace smoking: violating the health rights of others?

Finally, the appeal court ordered compensation payment to cover the funeral expenses, in addition to an annuity for each child of the victim equal to 20% of the mother's annual salary. The verdict has opened the way to litigation in many similar cases in Scandinavia; and it may influence the courts and concentrate the minds of unions and management in Canada in their negotiations about working conditions.

GILBERT

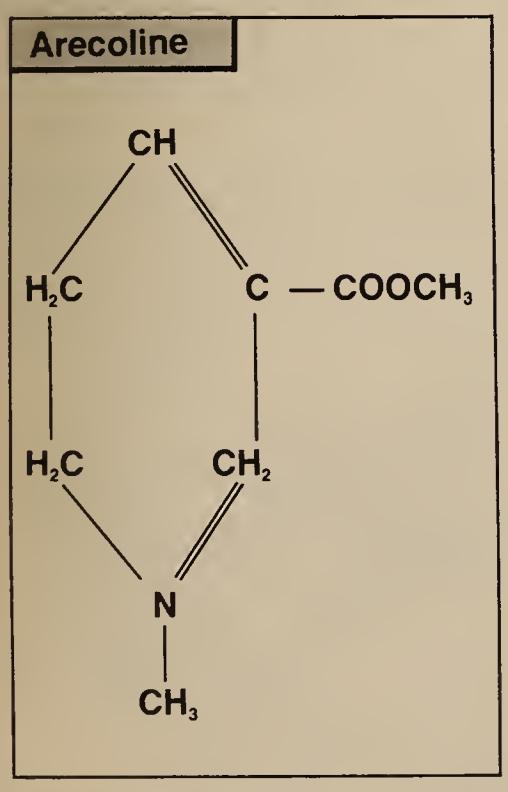
Arecoline: popular but unknown

Earlier this year (April, March), I wrote two columns on betel nuts, more properly known as areca nuts and used by about a billion people in Southeast Asia and the Indian sub-continent. The active pharmacological ingredient of betel nuts is arecoline, a drug with some slight resemblance to nicotine. This column briefly and loosely presents current information about the chemistry, pharmacology, and clinical uses of what is the world's fourth most popular psychoactive drug — after caffeine, alcohol, and nicotine.

Pharmacology

Arecoline is an alkaloid, meaning that it is an organic compound of plant origin containing nitrogen that reacts as a base, ie, it combines with acids to form salts. It is sometimes referred to as a tertiary amine because the nitrogen atom in the molecule is attached to three methyl groups. Arecoline is also regarded as being somewhat similar in structure to nicotine because the core of the molecule in each case is the pyridine ring of one nitrogen and five carbon atoms, as can be seen from the diagram.

Arecoline



Arecoline is known as a parasympathomimetic alkaloid because its effect on the body is as if the parasympathetic nervous system had been stimulated. The parasympathetic system is one of the two divisions of the autonomic nervous system, which is concerned with the body's involuntary actions. Activity in the parasympathetic division of the autonomic nervous system is generally associated with vegetative aspects of day-to-day living, such as the digestion and absorption of food, slowing of heart rate, and sexual arousal.

. . . current information about the chemistry, pharmacology, and clinical uses of the world's fourth most popular psychoactive drug

Effects on the body

Arecoline is also called a cholinomimetic or cholinergic drug because it produces effects similar to those produced by acetylcholine, a neurotransmitter found throughout the parasympathetic division of the autonomic nervous system and in part of the sympathetic division. Arecoline and certain other parasympathomimetic drugs are also known as muscarinic agents because they have actions similar to the drug muscarine, which is a potent stimulant of the parasympathetic division — 100 times more effective, weight for weight, than acetylcholine. Muscarine is the toxic constituent of the fly agaric mushroom, one of the species associated with mushroom poisoning. (Cognoscenti of the nervous system may know that arecoline also stimulates nicotinic receptors to a small degree.)

The precise mechanisms of action of arecoline on the nervous system are unclear, except that many parts of the spinal and cortical systems are involved.

One consequence of arecoline's cholinomimetic action is that the name of the drug is sometimes misspelled as 'arecholine.' The drug's name derives from its presence in the nut of the areca palm rather than because it has similar properties to acetylcholine.

The most conspicuous effect of arecoline is stimulation of various glands, causing profuse sweating and salivation, and increases in gastric and various other secretions. Bladder tone is increased, and the spleen may contract, causing increased counts of erythrocytes in blood.

As well as its arousal of the parasympathetic system, arecoline also produces general cortical arousal, at least at low doses. The likely picture — presently not well drawn — is of a mixture of arousal and depression, according to function, dose, and inherited responsiveness to cholinergic agents.

In contrast to other parasympathomimetic drugs, arecoline can produce increases in heart rate. Arecoline is, however, characteristic of such drugs in its ability to reduce elevated body temperature.

Arecoline appears, like caffeine, to be capable of interfering with genetic material. Administration of the drug to mice has produced damaged sperm heads and irregular incorporation of DNA into sperm. However, also like caffeine, there is no firm evidence of genetic damage resulting from ordinary human use of the drug.

In common with other stimulants, arecoline induces rapid-eye-movement (REM) sleep. This effect seems to be especially strong in depressive patients whose condition is regarded as endogenous, ie, very severe.

Another effect shared with stimulants generally is the production of tremor. One study showed that, in rats, production of tremor was dose-related and correlated with arecoline-induced elevation of regional cerebral metabolism.

Effects on performance

Some of the most interesting work on arecoline concerns its apparent ability to enhance learning, memory, and performance. Studies in both animals and humans have shown such an effect. Of special interest is a possible beneficial action on patients suffering from Alzheimer's disease.

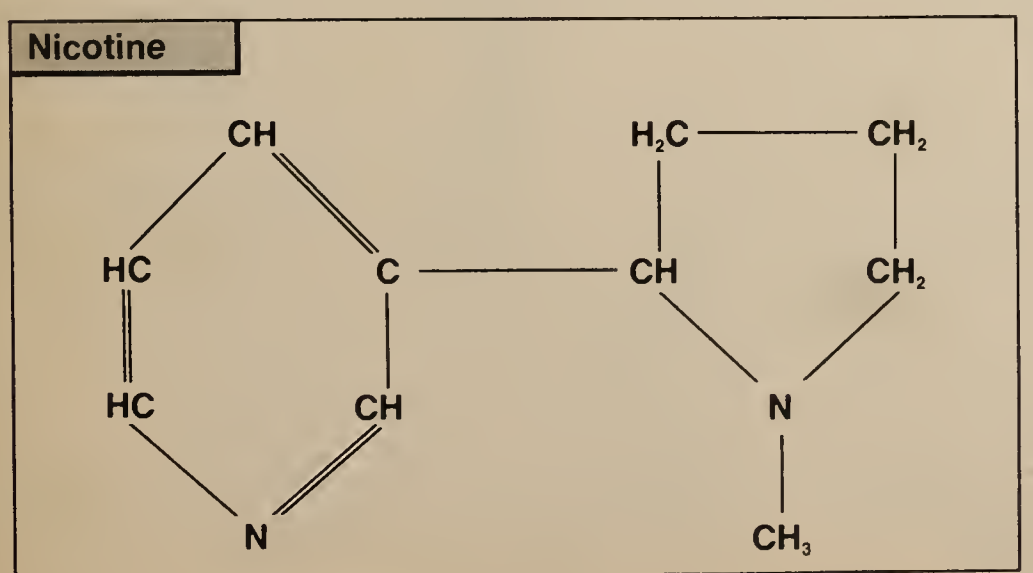
The chief effect seems to be on memory. The drug appears to be most effective when it is administered shortly after learning has occurred. Poor performers appear to benefit more than those who already learn or remember well.

Clinical uses

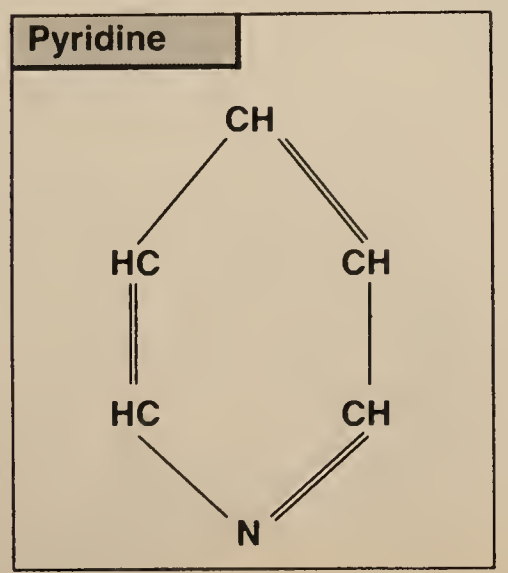
As well as its use as a possible aid in Alzheimer's disease, arecoline serves as an indicator of cholinergic hypersensitivity that some researchers believe underlies severe depression. The effect on REM sleep, noted above, is most commonly used as its induction by arecoline seems to vary with the severity of symptoms. Arecoline does not appear valuable as a treatment in cases of depression: it can cause an increase in mood disturbance, but it can also do this in control subjects.

What is lacking in the research literature is an assessment of arecoline as a drug used by a billion people for its psychoactive effects. Anecdotal reports attest to a feeling of well-being with regular use of betel chews and an increased capacity for work. Strong dependencies can result. Roughly 20 times as many people chew betel as use marijuana. Research is required into this popular human behavior, and also into the chronic effects of the drug.

Nicotine



Pyridine



By Richard Gilbert

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editonal (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Canadian national drug policy — it's up to Epp

Thank you for the special section: The making of a national drug abuse control policy (May).

This excellent paper, by the renowned Dr Bror Rexed of Sweden, for the world Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse, held in the United Kingdom (**The Journal**, April), should be drawn to the attention of all government ministers with responsibilities in this field, their political staffs, and their deputy ministers.

These are the officials who should and must be concerned with the development of an overall strategy and policy for Canada in this field. For now, no such national strategy exists here, although strategies have been developed in the United Kingdom, Australia, and the United States, among others. In the US, the strategy has been subjected to frequent revisions over the dozen or so years of its existence.

In my own experience of more than a decade in the illicit drug control field, there have been several beginnings of attempts to develop a strategy in Canada by people in middle levels of the federal bureaucracy — those who understand the highly complex field of illicit drug control and deal with such issues on a daily basis.

However, these attempts have failed and for a number of reasons: lack of understanding (at various levels leading to the top); lack of access to decision-makers (this appears to be regarded as an issue not worth disturbing bosses about on the way up to the decision-maker); and, lack of political pizazz (no large and/or vocal group of voters clamoring for action).

Another factor is judgements of the relative significance of illicit, addictive substances, based on numbers of Canadians affected.

Canadians whose health is affected by tobacco and alcohol number in the millions directly and indirectly; those affected by illicit drug abuse number only in the tens of thousands.

From the point of view of the total addictions picture, tobacco and alcohol are the right priorities, and Health Minister Jake Epp is to be congratulated on recognizing their importance and on being willing to tackle the powerful lobbies involved.

However, this does not relieve him of his responsibilities with respect to illicit drug abuse, in his admittedly monstrously complex portfolio — technically and politically.

Federally, the mandate for the control of drugs is given by the Narcotic Control Act and certain sections of the Food and Drugs Act, and responsibility lodged with the minister of Health and Welfare Canada. The lead, in Canada, has to be taken by this minister.

Yet, Mr Epp did not attend the Conference of Ministers of Health on Narcotics and Psychotropic Drug Misuse mentioned above, at which more than two dozen ministers of health from around the world discussed national and international drug issues.

The Canadian delegation was headed only by the deputy minister of health and welfare, although it did include experts R.A. (Ron) Draper, director-general, health promotion directorate, Health and Welfare Canada, and H. David Archibald, president of the International Council of Alcohol and Addictions, as well as founder and

Smith: several beginnings

chief for more than 20 years of Ontario's Addiction Research Foundation.

The Rexed paper was discussed at that meeting. So was one by Mr Archibald on international collaboration (**The Journal**, June). It stressed that for effective international action, collaboration and consensus at national levels are critical.

I hope the lessons were taken by Canada and will be applied here (for the development of a national strategy and policy).

Donald M. Smith, PhD
Ottawa, Ontario

Ed note: Dr Smith, who retired in January as senior scientific adviser, intergovernmental and international affairs, Health and Welfare Canada, is an authority on national and international narcotics matters and for many years led Canada's delegation to the United Nations Commission on Narcotic Drugs. In 1979, he served as chairman.

Linking marijuana use to AIDS risk is 'garbage'

I read with shock your article, US official links early marijuana use to AIDS risk (May).

How can a publication of your excellent status and reputation print such garbage? Such information might be useful in the search for causes of AIDS (acquired immune deficiency syndrome). It has nothing to do with the consequences of drug use.

The assertion by Ian MacDonald (MD, administrator of the United States Alcohol, Drug Abuse and Mental Health Administration) that AIDS and early marijuana use are related is about as useful as stating all AIDS victims drank milk when they were young or ate meat or breathed air.

This is an obvious attempt by Dr MacDonald, and now **The Journal**, to use the fear of catching AIDS to dissuade people from trying marijuana. Such scare tactics have been tried before and have failed miserably. Worse than useless, such tactics are harmful in the battle to prevent drug abuse by making all drug information appear biased and based on ridiculous assumptions.

This reminds me of the film, *Reefer Madness*, which was originally produced in the 1930s to frighten people about the consequences of marijuana use. It is now considered a comedy by drug users and abstainers alike.

You have done your readers a great disservice by passing on such myths and innuendo.

Bruce McCubbin
Addiction worker
Chatham, Ontario

The Journal welcomes Letters to the Editor. Letters bearing the full name and adress of the sender may be sent to: **The Journal**, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

FEATURE

Pioneer Lehmann looks at the aftermath

Psychoactives — reviewing the revolution

By Betty Lou Lee

TORONTO — Psychoactive drugs have revolutionized psychiatric care and emptied psychiatric hospital wards, but they have also created social monsters, says Heinz Lehmann, MD, a pioneer in their use.

Derelicts, revolving-door patients, and young, aggressive patients are an aftermath of that revolution, and little is being done to change their situation, he told the 20th anniversary symposium at the Clarke Institute of Psychiatry here.

Before the drugs, young, chronic, psychiatric patients were "institutionalized, quiet, and even docile." Now, many are in the community, said Dr Lehmann, professor emeritus, McGill University, Montreal.

"They do not comply with prescribed treatment, but demand social, clinical, and related services of their own choosing. They are all street-wise and frequently sell their prescription drugs.

"Many of them are tough, delinquent, and aggressive, and many are into street drugs.

Army of homeless

"So far, neither psychiatry nor any other sector of society has any handle on them."

Further up in the age scale, Dr Lehmann said, "de-institutionalization, the buzzword of the 60s, has resulted in many parts of the world in a growing army of homeless bag ladies and other derelicts on the streets.

"It is estimated that 40% of the 300,000 homeless in the streets of North American cities — some 120,000 individuals — are mentally disturbed: psychotics, alcoholics, drug abusers, former mental hospital patients, and others who should be, but cannot be, admitted to psychiatric hospitals because of new 'progressive' admissions policies.

"Within the overall poverty population, these derelicts are the poorest and most vulnerable of all. Many are at a loss to find even the well-worn paths in the labyrinth of welfare benefits.

Dr Lehmann: "We are seeing now a scramble for alternatives, novel living arrangements, and supportive services for these people. But, there is no prospect of any near-term achievement of that goal."

Revolving door

Many discharged patients could live in the community if they took their drugs, but many don't because of side-effects, forgetting, or the belief they don't need them.

"The result is the administrative nightmare of the revolving-door patient who may enter and leave the hospital several times a month."

Dr Lehmann is now deputy commissioner for research for the New York State office of mental health in Albany.

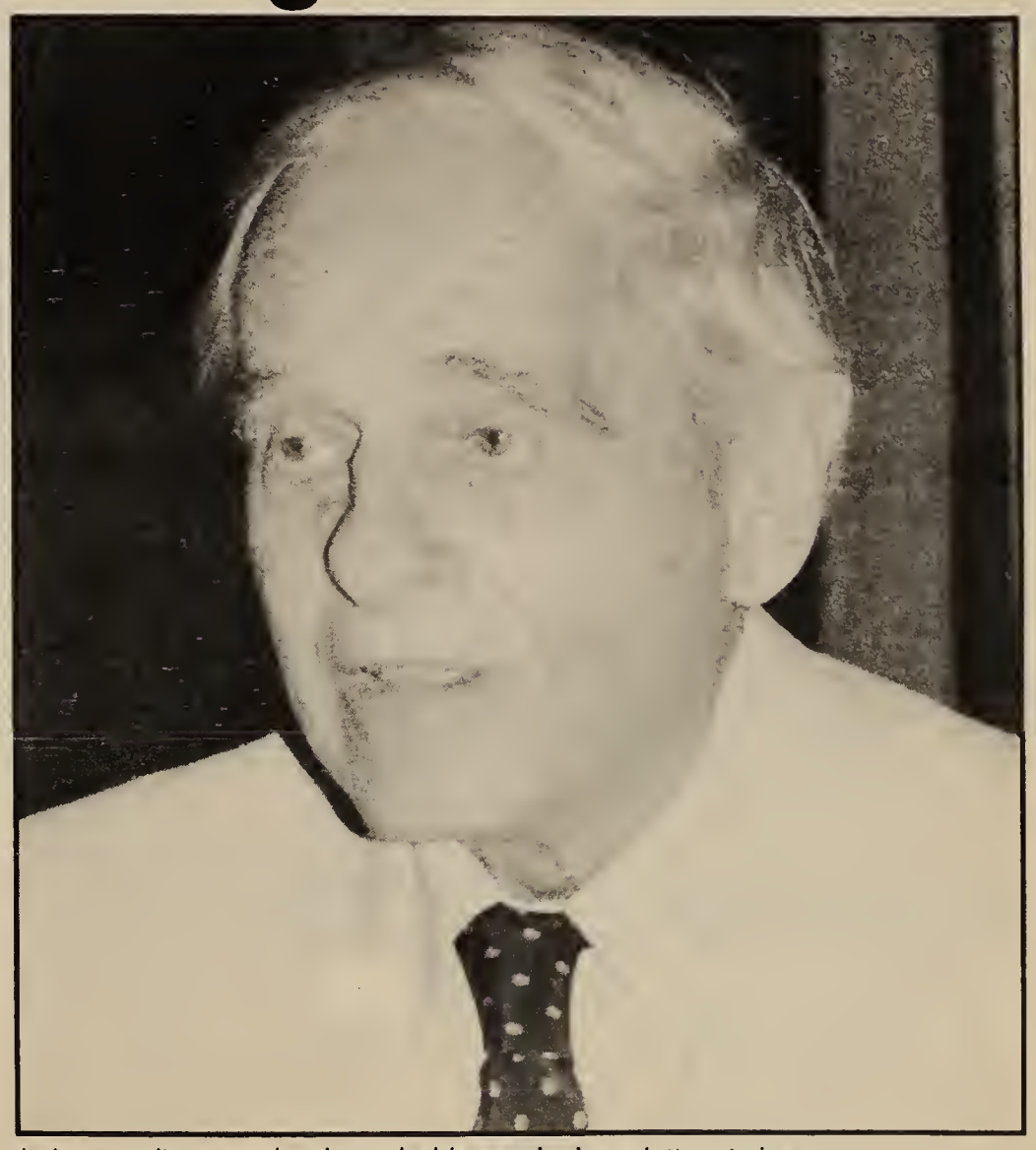
In 1953, he was the first psychiatrist in North America to give psychoactive drugs to patients — a trial of chlorpromazine (eg, Thorazine) with 75 schizophrenics at Verdun Protestant Hospital (now Douglas Hospital) in Montreal.

Within two weeks, some were in remission and ready to leave hospital.

"I assumed we were seeing a series of flukes, perhaps resulting from a strange, chance-selection in the sample. It seemed almost as improbable as winning $1 million twice in a lottery.

"Much as I wanted to believe what I was seeing, I didn't."

For two years, he didn't dare attribute specific anti-psychotic effects to the new drugs; when he did introduce that term in 1956 at a meeting of the Canadian Medical Association, he did so "apologetically, and more as a metaphor than a designation."



Lehmann: it seemed as improbable as winning a lottery twice

It was another two years before he could also accept that the drugs were useful for the "hopeless" chronic patients packing the back wards of psychiatric hospitals.

The new awareness of the great power of drugs gave birth to a two-faced monster: "the emergence of street drugs for recreational purposes, and the over-dependence on prescribed tranquillizers . . . . Worldwide epidemics of drug abuse broke out."

Dr Lehmann, a member of Canada's LeDain Commission of Inquiry into the Non-Medical Use of Drugs in the early 1970s, said the anti-drug backlash of that decade was a result of "the destructive aspects of the drug scene, the often questionable tactics of the pharmaceutical industry, the oversell by some members of the psychiatric community, and the disenchantment of the legislators and other 'budgeteers.'

Genuine need

"Not only were illegitimate uses of drugs denounced, but also legitimate uses and prescribers were implicated. Physicians put away their prescription pads, and probably many patients with genuine need for tranquillizers, sedatives, or drugs for insomnia, were scared away from even reasonable, limited use of such drugs.

"Recent epidemiological studies, as well as some of today's most knowledgeable observers, indicate that today psychoactive drugs are actually underprescribed, in view of the need for treatment of diagnosed psychiatric disorders.

"The patient who is suffering from symptoms which are quite treatable by tranquillizers is being told — by physicians, self-help groups, friends, and the media — that he should instead try jogging, relaxation exercises, meditating, a diet change, yoga, or just personal ego power, to solve his problems.

"If he cannot manage any of these alternatives, and feels too guilty to take tranquillizers, he finds himself lodged between a rock and a hard place."

From psychiatric wards . . .

. . . to the streets

NEWS

Press coverage slowing down drinking drivers

By Heather Walker

VANCOUVER — Greater press coverage of drunk driving leads to a direct decrease in the number of drunk-driving incidents, says a Vancouver researcher here.

William Mercer, PhD, research director for British Columbia's CounterAttack program, studied the relationship between articles on drunk driving and alcohol-related traffic accidents between 1980 and 1984.

"We had learned in an earlier study of factors that might affect the incidence of drinking-driving accidents, that media coverage was the only factor that made any difference," Dr Mercer told **The Journal**.

"This study was to determine which kind of press articles were better for deterring drinking driving. The answer was that the best kind was more articles."

Dr Mercer reviewed articles in the *Vancouver Province* newspaper during the four-year period. The articles were coded according to content: alcohol-related traffic accidents, anti-drinking driving campaigns, and groups mentioned, such as CounterAttack, the Ministry of the Attorney-General, and the police.

CounterAttack symbol

But, none of the factors could be shown to have any effect on numbers of drinking-related accidents.

Dr Mercer: "This could be because no matter what the specific content of the articles, all are opposed to drinking driving. They're on an overall theme."

He added there are some practical applications for his research.

"This shows we don't need big, banner headline articles because it's better that we get a lot of stories in than one big one. So, what we're doing now is sending out clip sheets with a lot of small stories about drinking driving. and these articles go into the paper in places where there's a little extra space that needs filling."

The result is increased coverage of drunk-driving issues with relatively little effort.

Dr Mercer said the effectiveness of press coverage in reducing drunk driving continues throughout the year, including during the Christmas and New Year period.

Tar, nicotine yields

OTTAWA — Some smokers could be getting up to three times more tar and nicotine than the values printed on their cigarette packages indicate. An analysis done by Labstat, Inc for Health and Welfare Canada shows some smokers may inhale up to one litre of smoke from a single cigarette. Thus, yields per litre estimate the maximum amount of toxic substances per cigarette to which some smokers are exposed. Tests on 44 manufactured cigarette brands and four brands of fine-cut tobacco for hand-rolled cigarettes compared the tar and nicotine values printed on the packages with the actual rates found in one litre of smoke.

Yield printed on package in milligrams per cigarette		Brand Name	Yield in milligrams per litre of smoke		
Tar	Nicotine		Tar	Nicotine	Carbon Monoxide
1	0.1	Medallion Ultra Mitd KSFT	4	0.6	5
1	0.1	Craven A Ultra Light KSFT	4	0.6	5
1	0.1	Macdonald Select Ultra Mild KSFT	5	0.7	6
3	0.3	Viscount Extra Mitd KSFT	11	1.4	11
3	0.3	Viscount Extra Mild Menthol KSFT	13	1.5	13
4	0.4	Matinée Extra Mild KSFT	12	1.4	13
4	0.4	Vantage Light KSFT	12	1.4	14
4	0.4	Viscount Extra Mild 100s FT	11	1.2	12
4	0.4	Macdonatd Select Speciat Mitd KSFT	14	1.5	14
4	0.4	Craven A Speciat Mild KSFT	15	1.7	15
6	0.3	Gitanes Light Regular FT	28	1.8	35
8	0.5	Matinée Regular FT	30	2.5	39
8	0.8	Export A Extra Light Regular FT	31	2.9	33
8	0.8	Benson & Hedges 100's Deluxe Extra Light	26	2.6	29
9	0.8	Players Extra Light Regular FT	28	2.9	30
9	0.9	Silk Cut KSFT	26	2.7	29
9	0.6	Craven A Regutar FT	33	2.7	34
9.5	0.6	Gitanes Regular FT	38	1.8	61
10	0.8	Export A Light Regutar FT	36	3.3	38
10	0.9	Belvedere Extra Mitd Regutar FT	42	3.5	47
11	0.7	Gauloises Regular FT	40	2.1	66
11	0.8	Craven A Menthol KSFT	34	3.0	33
11	0.8	Matinéc KSFT	34	2.8	40
12	0.9	Rothmans Spectat Mitd KSFT	31	2.8	38
12	1.0	Craven A KSFT	34	3.2	33
13	1.0	DuMaurier Regular FT	44	3.8	58
13	1.0	Export A Mcdium Regular FT	48	3.8	54
13	1.0	Players Light Regutar FT	45	4.1	45
14	1.1	Dunhill International FT	33	3.0	38
14	1.1	No Name (Provigo) KSFT	48	4.1	48
15	1.0	Export A KSFT	41	3.4	50
15	1.0	Export A Regular FT	57	4.2	64
15	1.1	Belvedere Regular FT	55	4.5	58
15	1.1	Mark Ten Regular FT	58	4.3	67
16	1.1	Cameo KSFT	44	3.7	52
16	1.2	Peter Jackson KSFT	42	3.8	51
16	1.1	Number Seven KSFT	40	3.4	42
16	1.1	Mark Ten KSFT	43	3.6	47
16	1.2	DuMaurier KSFT	43	3.9	50
16	1.2	Players Regular FT	51	4.4	54
16	1.1	Rothmans KSFT	40	3.4	43
16	1.0	Export A Regular Plain	60	4.5	45
16	1.1	Players Regular Plain	59	4.7	48
17.5	0.9	Gitanes Regular Plain	80	3.8	67
		Fine Cut			
*	*	Craven A Special Mild	32	2.5	38
*	*	Belvedere Light	38	3.0	40
*	*	Players Light	40	3.0	42
*	*	Export Light	40	3.0	41

**Manufacturers do not list tar and nicotine on packages.*

Labstat's yields are determined by machine smoking 100 cigarettes under the following conditions: Puff volume: 35 millilitres
Puff duration: 2 seconds
Puff interval: 58 seconds
Butl length: 30 millimetres

KS: King Size
FT: Filter Tip

Groups form across Canada

Parents' network spreading

By Elda Hauschildt

SASKATOON — PRIDE Canada (Parent Resources Institute for Drug Education) is on its way to establishing a national network of parent groups.

The organization, which is affiliated with the United States PRIDE group, held its first national conference here in 1985. More than 500 people attended (**The Journal**, July, 1985).

"This year, we doubled our numbers for both adults and youth; we had more than 450 adults and more than 500 young people here," PRIDE Canada executive director Eloise Opheim, told **The Journal** during the second national conference here.

"We have nine PRIDE groups in our home province of Saskatchewan, and we have groups forming from Cape Breton, Nova Scotia to Kelowna, British Columbia. We've even been asked to go up to the Northwest Territories to talk to some parents there."

PRIDE Canada, which is based at the College of Pharmacy at the University of Saskatchewan here, sees itself as a resource group for other Canadian parent groups.

Ms Opheim: "Our mandate is to help people form parent community groups. We don't care if they call themselves PRIDE; the important thing is for them to get going and do something. They can call themselves PRIDE if they like the name and they like the logo — and it makes us stronger — or they can call themselves anything they like.

"We can act as consultants and tell them the practical steps they need to take to get started."

She believes there has been "an awareness and a concern about drugs that overwhelmed Canadian parents about the same time.

"And, parent groups started to form. But, Canada being such a large country, we just didn't know of each other's existence. Our national conference helps us find each other and, hopefully, join forces."

PRIDE in Saskatoon has been working closely with the provincial Department of Education.

More than 70 assistant principals from city schools attended a one-day PRIDE seminar on the four stages of drug dependence with Miller Newton, PhD, president and clinical director of KIDS, in River Edge, New Jersey just prior to the PRIDE conference. School administrators, teachers, and counsellors also attended the PRIDE meetings.

Opheim: do something

First national conference focuses on women's issues in addictions

GENEVA PARK, Ontario — More than 150 health and social service workers, volunteer and paid, from across Canada met here for the first-ever National Consultation on Women and Drugs.

The three-day meeting, sponsored by the health promotion directorate, Health and Welfare Canada, focused on prevention and education aspects of women's use of alcohol, tobacco, minor tranquillizers, and anti-depressants. (See stories pages t and 3.)

A provincial consultation was held in Ontario in t975, and recently, the Addiction Research Foundation in Toronto held a seminar on sex differences and alcohol at its School for Addiction Studies (**The Journnt**, June).

Karen Madden, project manager for the consultation, told **The Journal**: "We invited people involved in service at the community level, front-line workers.

"All of these people tend to work in isolation, and they need to know they are right in seeing the issue of women and drugs as important. By coming together, they see there are other people working in the same areas and that, yes, the issues are important.

"Because they are working at the community level, they can exchange ideas on what other people are working on, which programs work, and which do not, within women's reality."

US court okays roadblocks to curtail intoxicated drivers

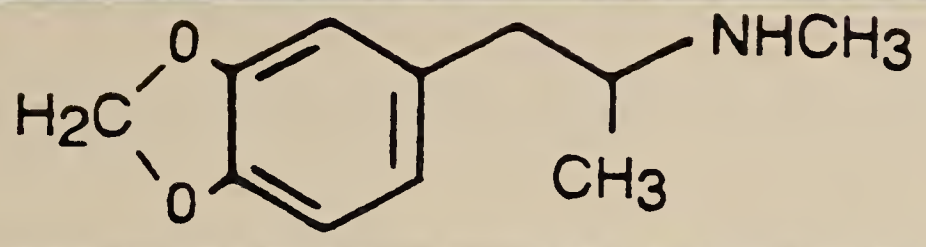
WASHINGTON — The United States Supreme Court has let stand legislation by the state of Virginia on roadblocks set up to catch drunk drivers.

The court — although it set no precedent — refused to hear the appeal of a man convicted of drunk driving after being caught at a roadblock. The appellant claimed the roadblock violated constitutional restrictions on unreasonable searches.

At least 30 US states and the District of Columbia have from time to time set up roadblocks to catch drunk drivers. The Supreme Court, by refusing to hear the appeal, gives tacit approval to these actions.

The appeal was against a decision by the Virginia Supreme Court that roadblocks were a minimal inconvenience when balanced against the strong interest by the state in "protecting the public from the grave risk presented by drunk drivers."

MDMA



To outside observers the setting seemed appropriate. MDMA, a multidisciplinary conference, was held for two days at the addiction studies program of the Merritt Peralta Institute in Oakland, California. But, many members of the audience looked as though they had taken 20 years to drift across the Bay Bridge from San Francisco: they were still dressed for the 1960s.

What LSD was to those earlier years, MDMA (3,4-methylenedioxymethamphetamine) or "ecstasy" is to the 1980s: a psychedelic drug that some claim produces a tremendous psychotherapeutic response.

Although MDMA has been around since 1914, and researchers could legally formulate it, it was discovered by the public in 1984, and anecdotal claims by therapists about its powers began to swamp the United States media. In 1985, the US Drug Enforcement Administration, in an unprecedented emergency scheduling, placed MDMA in schedule 1 (no use at all — even therapeutic) of the Controlled Substances Act.

The conference, co-sponsored by the Haight-Ashbury Free Medical Clinics' training and education project, examined MDMA from a multitude of angles.

Those who attended heard a lot of what they wanted to hear, and much they didn't. While rippling choruses of delight greeted advocates of MDMA for psychotherapeutic use, only the rigid could fail to be impressed by the toxicological evidence or the disquiet of some doctors at any experiment which can raise blood pressure to dangerous levels, however transient.

And, despite its glamorous names — "ecstasy," or "XTC," or "Adam" — whatever else it is, MDMA is not a drug for improved sex.

Washington contributing editor *Harvey McConnell* reports.

McConnell

SAN FRANCISCO — Mammoth publicity about MDMA produced some misleading assumptions.

It is not a new drug but an old one: synthesized in 1914, it lurked in obscurity until it began to appear on the streets in the 1970s and caught the public eye in 1984, when some psychotherapists started touting its powers.

Nor is MDMA a street-synthesized ("designer") drug. It is a ring-substituted amphetamine congener of a class often referred to as methoxylated amphetamines. It has as a structural congener, MDA or 3,4-methylenedioxyamphetamine.

The confusion of MDMA with the real and highly dangerous street-synthesized drugs, such as chemically altered analogues of pethidine (eg, Demerol) which produced Parkinson's disease in street drug users, and other drugs, worries Richard Seymour, director of the Haight-Ashbury training and education project and author of a recent monograph on the drug.

While MDMA is certainly an analogue in the methamphetamine series, it, as with analogues of legitimate drugs, is certainly not in the designer drug category. The danger is that confusion of products of legitimate experimentation with products of street-synthesized experimentation (designer drugs) could be reflected in future legislation and hinder experimental development of legitimate drugs.

Under emergency legislation drawn up in 1984 to deal with the designer drug phenomenon, the US Drug Enforcement Administration (DEA) has the power to put a compound in schedule 1 (along with such other drugs as heroin, PCP, and methaqualone [eg, Quaalude]) for a year, with a six-month extension. An administrative law judge is currently considering evidence given in public hearings last year, and his decision is expected soon on whether MDMA should be rescheduled.

The focus of antipathy to the US government action at the conference was on Frank Sapienza, a chemist in the DEA's office of diversion control in Washington. He clearly anticipated it.

The DEA had known MDMA was available on the street since the early 1970s, but was not then aware of any medical use.

In the 1980s, the agency heard from its own agents and from law enforcement officials that people were being seen under the influence of the drug, and questions were asked as to why it was not scheduled.

Mr Sapienza said the decision to schedule a drug is based on medical and scientific evidence. Four factors are taken into account in placing a drug in schedule 1: does the drug, taken in sufficient amount, present a hazard to the health or safety of an individual or community; is there significant diversion from a legitimate source; does an individual take the drug on his or her own initiative and not on the advice of a doctor; and, is the drug so related in its pharmacology to substances with known abuse potential that it is likely to have the same potential for abuse?

Abuse potential

The pharmacology does not have to be exact; enough pharmacological similarity to known substances which have known potential for abuse is sufficient.

Mr Sapienza: "I am not going to say that because MDMA is closely related chemically to MDA, it has the same potential for abuse. But, I will say MDMA shares certain properties with MDA and with methamphetamines, which makes it highly likely it will have some abuse potential."

He repeatedly hammered home to questioners and critics that the DEA has to carry out its mandates from Congress via federal legislation; any changes in the laws will have to be made by Congress, and questions should be raised with legislators.

From the epidemiological point of view, MDMA is a bit player on the drug scene, said John Newmeyer, PhD, epidemiologist at the Haight-Ashbury clinics. Digging through traditional sources of drug use/abuse trends, such as arrests, treatment admissions, and overdoses, produces "virtually no nuggets" in the case of MDMA.

An examination of records at the San Francisco coroner's office found little: in 1984 data, the latest available, MDMA was mentioned in only two of 200 drug-related deaths and then only as an incidental, unrelated to cause of death. Records of the DEA's Drug Abuse Warning Network of emergency rooms around the country show virtually no mention of the drug.

Dr Newmeyer said even in San Francisco, which can be considered the epicentre of MDMA use, the clinic sees only three or four users a month. Thus, MDMA use overall "is too small a phenomenon to be detected by nationwide systems and surveys currently in use.

"Certainly, MDMA is not having the impact on the public in the incredible way cocaine did five or six years ago. Only a tiny minority of people use MDMA. From the epidemiologist's point of view, this drug is not interesting."

The nationwide publicity about MDMA in mid-1985 had its effect on the street: both sales and price rose. The drug is most popular on the US East and West coasts and, for some reason, among college students in Texas.

At least with MDMA, the buyer more or less gets what he pays for. Charles Renfroe, director of information services for Pharchem Laboratories in Palo Alto, California, said the company's non-profit wing, Analysis Anonymous (which ceased operations in 1983), found over the years that samples submitted to it were for the most part pure MDMA.

More or less the same purity has been found in samples analyzed recently at the Haight-Ashbury clinics, declared Greg Haynor, PharmD: eight out of 10 were MDMA, and the other two were MDA.

The information that the MDMA available on the streets is what it is purported to be pleased some of its adherents. But, as they learned on day two of the conference, there is a sting in the tail.

Dr Haynor vouchsafed that probably most research with MDMA ceased once the drug was placed in schedule 1.

He pointed out that since the late 1960s, the clinic has treated people for abuse of the methoxylated amphetamines, but it was not until 1983 that it started getting calls about MDMA from California's Carmel-Monterey area. At first, because there are so many names for street drugs, clinic staff were not sure it was MDMA.

So far, the clinic has treated some 450 people who had been using MDMA or related compounds on a sporadic and not day-to-day basis. There is added confusion because people are not taking just one drug, but mixing and matching.

Dr Haynor: "We do see a lot of amphetamine-like reactions to the drug, like increased heart rate, tremor, tight jaw, grinding of teeth, muscle tension, lots of complaints of back pain, numbness in extremities, a feeling of being cold, tingling sensations, phobic luminescence around objects, and increased color acuity. Also, objects seem to be shaking, especially as the effects of the drug are coming on."

Another LSD

Some users also complain of ataxia, nausea, vomiting, crying, insomnia, nystagmus, blurred vision, headaches, and sweating — all expected in the late 1960s and 1970s in those using MDA. Overdose effects are similar to those of the amphetamines: tachycardia, raised blood pressure, tremor, and increased temperature.

How valid are the claims that MDMA is as valuable as LSD was in psychotherapy, with the added advantage that MDMA is not as powerful a drug?

Enoch Callaway, MD, professor of psychiatry, University of California, San Francisco (UCSF), in reviewing clinical use, said LSD was used a long time before it was banned. "It certainly produced fascinating effects and had an impact on society. But, whether it had a medical use or not, I don't think has been established.

"I don't think there has ever been a controlled study of LSD which showed it did anything medically therapeutic."

However, he said, if it's the DEA that is supposed to decide if MDMA has a medical use — that is, enforcement officials judging medical issues — that "poses a problem, and we have to address that issue."

There are many anecdotal reports of MDMA's efficacy even in the treatment of alcoholism and, most recently, in treatment of cocaine abuse. In the world of science, if something really works, it moves from the fringe into the mainstream: for example, levodopa (eg, Dopaidan) in the treatment of Parkinson's disease.

Dr Callaway: "It remains to be seen if MDMA fares better than LSD. The work has to be done. We cannot simply rely on the good offices of our intrepid explorers who come back reporting there is a mountain of gold."

Ostensibly, both science and the public demand rigorous clinical trials and replications of results. But, how is that possible with a drug for which the results are always subjective and which is used within a discipline no one has yet proven works?

This was the conundrum put by James Bakalar, Massachusetts Mental Health Center and department of psychiatry, Harvard Medical Center, Boston. In research, psychotherapy has been plagued, he said, by "a lack of consensus, empirical doubts, and conceptual confusions."

There is general agreement in medicine about some of the factors which can produce a placebo effect in both clinical trials and experiments: the charismatic authority of the healer, patient confidence in the proceedings, patient expectations, even the tensions between the two parties.

But, Mr Bakalar pointed out, in psychiatry in particular, it is very difficult to separate the characteristic mechanisms of such a trial from the incidental effects of healing and helping in general.

Those who attempt to evaluate psychotherapy often just muddy the water. He cited the definition of psychotherapy from a major study several years ago: "Psychotherapy is the application of techniques derived from established psychological principles by persons qualified in the principles to apply the techniques."

Mr Bakalar: "Of course, the question is whether there is such a thing as established psychological principles, especially as no type of psychotherapy has been shown to be better than any other for particular emotional problems or particular psychiatric conditions."

The threads are as tenuous with MDMA: claims are no easier to establish than those for other forms of psychotherapy, and there are the same problems of placebo effects and attempts at blind experiments. "It is the experience itself, and knowing you are going through the experience, that is supposed to create the valuable change," he observed.

Before any psychedelic drug therapy becomes acceptable, it must be proven that it is equal to, or better than, any form of psychotherapy for at least some patients in some conditions.

Mr Bakalar: "Psychotherapy is often used by people who are not emotionally ill in the same sense as people who go to the doctor are physically ill. They are simply dissatisfied with some aspect of their lives and want to improve it. And, improvement depends on the judgement of the therapist and the patient."

Many consider it is not respectable to use drugs in such cases; there is great suspicion of claims about mysticism or expanding the consciousness.

What many in the audience were clamoring to hear, they got from several psychiatrists and psychotherapists. And then, they heard what they didn't want to hear from the toxicologists and pharmacologists who followed.

George Greer, MD, a psychiatrist in private practice in Santa Fe, New Mexico, reported on the results of a private study he did with 29 patients using MDMA in doses of from 75 milligrams to 125 mg. He and his wife, a psychiatric nurse, looked into the medical history and psychological problems of patients before the drug was used. In 1983, they did a two year follow-up. He said the report was "a little bit tighter on anthropology than neuroscience."

Intimacy aid

The critierion was to help patients with whatever the patients deemed as problems, "and actually they were more the investigators and the experimenters than I was. They decided what the purpose of the session was, and they assessed to what degree or not they achieved those goals."

As every patient was different and had differing problems, he really engaged in 29 different studies using MDMA.

Dr Greer said the most common benefit reported was enhancement of communication or intimacy during the sessions. All those taking part were either couples or in groups of up to five members.

(Continued on page 12)

(Continued from page 11)

Those who had more difficulty with their emotions during the session reported more benefit after the session was over. MDMA "seemed to accelerate very intensive psychotherapy."

At follow-up two years later, Dr Greer said, many couples reported the session "seemed to make a lasting difference in the way they related to each other."

Many of the patients used marijuana, alcohol, and caffeine, and several used cocaine, although none were abusers. Many said they cut down use of various substances after the session and cocaine users said the drug no longer seemed so appealing.

There were side-effects, none serious: jaw clenching, nausea, loss of appetite, insomnia, tiredness the following day.

MDMA was not given to patients with serious psychological problems.

The most lyrical praise for MDMA and what he claims it can do came from Rick Ingrasci, MD, director of the Turning Point Family Wellness Center, Watertown, Massachusetts. He lobbied on television and in Washington at the DEA hearings in defence of the drug.

He vowed to keep fighting "people who are for some reason threatened" by a drug which "enhances the therapeutic process."

Dr Ingrasci first used MDMA with patients 15 years ago, has experimented with the drug several times, and is convinced it is a "very useful catalyst in psychotherapy." He does not consider it wrong to give a drug which has been around for years, and used thousands of times with no seeming chronic toxicity, especially if it is given only once or twice.

Dr Ingrasci was adamant: MDMA "worked again and again and again. I never heard the day after, the week after, the month after, the year after that 'it really screwed me up.' "

Rather, he said, MDMA produced what he can only call "phenomenal effects in the therapeutic process — a sort of quantum leap, shortening the process for people who are trying to peel the onion and get back to themselves."

The experience

Unlike LSD use, he added, MDMA use is "the new frontier" with convergence of psychotherapy and pharmacology.

He found in using MDMA for more than 150 clients that many "get unbelievably honest with you." People who have been in therapy for six months or a year start to tell him things he has not yet heard.

Equally enthusiastic about MDMA was Philip Wolfson, MD, clinical faculty, school of medicine, University of California, Los Angeles (UCLA), who has 16 years in psychiatric practice. He believes MDMA "provides, in its totality, an unprecedented access to an experience that human beings value and they wish to have an opportunity to repeat at a future date."

Another truth about MDMA, he said, is an almost universal observation that "those who have had the MDMA experience wish to share it with others and believe that they have the power to do so." Nor has anyone been able to say otherwise after hundreds of thousands of experiences with MDMA.

Dr Wolfson acknowledged there are hazards and difficulties with the drug and, as all chemicals, it can produce an unpredictable response. "On the other hand, MDMA users are not dropping like flies. We are here."

He believes psychotherapeutic use of MDMA offers the possibility of a rapid and significant break with defence structures and can lead to "psychic integration" and "identity structure." It offers the chance for a shift from a "negativistic self-hating state of being," to one in which love of others is possible and a shift from isolation to "interpersonal contact and intimacy."

Dr Wolfson believes MDMA could be effective in depression, marital discord, couples' problems, and perhaps treatment of psychogenic pain disorders.

A completely different use was suggested by June Riedlinger, a pharmacist from Chicago suicide prevention. There are no data to show it is effective as such, she said, but the implications are there in the research done to date.

Ms Riedlinger said MDMA should be tried in the treatment of mental problems commonly attributed to suicidal patients. It might help reduce the official (but probably higher) figure of 30,000 suicides a year in the US.

Although he believes the study "doesn't make a bit of difference," Joseph Downing, MD, who is in private practice in psychosomatic medicine in San Francisco, reported on the biomedical, cardiovascular and neurophysiological, and inconsistent biochemical changes in a group of volunteers who took MDMA.

Safety queries

The 1984 experiment was not with a naive drug population: the 14 volunteers had used MDMA a median 8.5 times. The study found that blood pressure peaked at a level equal to that in slow jogging and the higher the dose of the drug, the higher the blood pressure readings. There was no reported physical or psychological damage either during the 24-hour experiment or at three month follow-up.

Dr Downing said the conclusion was MDMA was reasonably safe if used sparingly and episodically, although any drug that raises blood pressure and causes ataxia is potentially unsafe.

Any euphoria about reports of what MDMA might do in psychotherapy was tempered, for those willing to listen, by the toxicologists.

David Smith, MD, medical director of the Haight-Ashbury clinics and research director at the Merritt Peralta Institute Chemical Dependency Hospital, recounted that scheduling MDMA has had no significant impact on its use on the streets, or on the purity of the dosages. But, it has compromised therapeutic research.

On the other hand, he added, scheduling has increased "do-it-yourself psychotherapy." And, this raises concerns about people who may have psychological reactions precipitated by the drug and have no one around who knows how to handle the panic and anxiety.

Dr Smith said that toxicology "is not a science invented as an evil conspiracy with the government to prevent progress in therapeutic drug research."

He also chided: "Many things are being said about MDMA, and people saying them should know better."

The similarities to other stimulant toxicity is evident in MDMA: "It clearly elevates blood pressure, clearly elevates pulse rate, and if you have a compromised cardiovascular system to begin with, it may produce severe untoward reaction." Toxicity and psychosis can be the same with MDMA, amphetamines, or cocaine.

When questions are raised about the adverse effects of drugs, the past is reviewed for guidelines to the future.

Dr Smith: "One of the things which happened when we started to see an increased incidence of MDMA adverse reactions was that people said, 'Oh, that couldn't be MDMA.' It is similar to what happened when people had bad acid trips in the 1960s. People said, 'It is bad acid.'

"Well, we analyzed the LSD in the 1960s, and it was pure LSD. We have analyzed the MDMA in the 1980s, and it is pure MDMA."

It is this purity that leaves no doubt among doctors and pharmacologists at San Francisco General Hospital that a young woman nearly died recently from toxic reactions to an MDMA dose considered in the therapeutic range.

Howard McKinney, PharmD, told the audience that 20 minutes after taking a dose of MDMA with a friend, the young woman was out of control and in a very short time was rushed to the hospital combative, delirious, and agitated.

Within half an hour, the medical team skilled in treating drug overdoses began the regimen they have learned is best: proactive action instead of responses to reactions. They battled to lower her body temperature, which zoomed, and raise her blood pressure, which had dropped precipitously. Other body systems were also compromised.

Five days later the young woman was released from hospital.

Dr McKinney told questioners the team had run five separate tests including gas chromatography and mass spectrometry on the remaining four of the six MDMA packets the women had purchased. In every case, "it was MDMA and nothing else."

Dr Smith, commenting on Dr McKinney's report, said that the toxic reactions of the young woman were similar to those of people who have died of uncontrolled malignant hyperthermia from amphetamine overdoses.

Clearly, there are many toxicological questions unanswered about MDMA," he added. "We must try to get a balance between any beneficial effects and side-effects, and particularly disturbing is if these untoward side-effects are coming out of the therapeutic dosage range."

One of the major scientific studies of MDMA has been done with rats at the University of Chicago by Charles Schuster, MD, L. S. Seiden, PhD, and George Ricaurte, PhD. They have studied the effects of both MDA and MDMA on the rat brain.

Dr Ricaurte, now of Stanford University, Stanford, California, impeccably outlined their studies and illustrated with dramatic, silver-stained slides of portions of the rat brain.

He said MDMA produces long-lasting chemical alterations in the serotonergic neurons by actually inducing degeneration of the serotonergic nerve terminals. In addition, it affects groups of neurons whose chemical identity is not yet known, but whose cell bodies are located in a highly restricted region of the somatosensory cerebral cortex.

Dr Ricaurte: "At this time, we have no idea what the long-term consequences to the animals are of the toxic effects of MDMA. More importantly, we don't know whether MDMA produces similar neurotoxicity in the brains of humans.

Nothing magic

"However, given the clear neurodegenerative action of this drug in animals, in my opinion it would be prudent to withhold administration of MDMA for either medical or non-medical use."

He pointed out to questioners, who noted the high doses of MDMA given to the rats, that over the years numerous studies on a variety of drugs have shown repeatedly that dosage levels that will produce adverse effects in primates or humans are much lower than those needed to produce similar effects in rats.

Ronald Siegel, PhD, put to rest any idea MDMA is in some way unique. He has had research experience over the years with mescaline, LSD, peyote, all kinds of isomers and variations on those, and more recently with cocaine, amphetamines, and PCP.

"One thing I have learned over the years — and I don't think it can be emphasized too often — drugs do not work in any magical way." Dr Siegel, is a psychopharmacologist at the department of psychiatry and behavioral sciences, School of Medicine, UCLA.

Dr Siegel: "We have the opinion in this country that minutes or hours after using a drug such as MDMA, the individual will be transported into some wholly self-actualized, empathic, insightful individual. Another view, with considerably more political power, would have you believe the individual would be turned into some nauseated, hyperthermic, catatonic idiot.

"Drugs like MDMA don't work in any magical way. They are simply chemical substances with certain pharmacological properties and behavioral possibilities."

One can see such variations in the most common group drug experience: a party where alcohol is served. The drug, the length of time it's used, the setting, and the expectations and attitudes of having a good time are common.

Dr Seigel: "Some people become boisterous and aggressive; others become passive and lethargic, and still others amorous and lascivious.

"It is not the magic of alcohol, it is the personality of the individual and the pharmacology of the drug and lots of other non-drug variables."

Dr Siegel said his studies lead him to think MDMA does not have a high abuse potential, and it is "nothing I would get alarmed about from the public health point of view."

The fact is, most drug users don't like MDMA, he said. He and his colleagues screened 1,076 regular drug users and found only 416 were MDMA users, and 90% of them had used it only once, not liking the undesirable side-effects.

Sexual issues

The most obvious alleged attraction of "ecstasy" was left to the last item on the conference agenda. It was just as well, because the very few data available indicate MDMA users do not rip their clothes off in sexual frenzy.

Or, if there are people who do find it an aphrodisiac, they are not telling, say John Buffum, PharmD, clinical professor of pharmacology, UCSF, and Charles Moser, PhD, associate professor, Institute for Advanced Study of Human Sexuality, San Francisco.

Dr Buffum said a preliminary survey they have made among 22 women and 23 men — biased because most were highly educated and married — showed MDMA does not seem to increase sexual desire directly: most said it produced more emotional closeness.

Dr Moser: "The concept of using this drug in sex therapy is very appealing, but very little has been done to show that any of the psychoactive drugs has had any beneficial effects.

"For people to be rushing in and trying this around sexual issues is probably not called for. Any use in a sexual way must be taken slowly."

Dr Moser questioned some assumptions made about MDMA and intimacy.

He explained: "One of the problems about intimacy is that it presupposes a female model, and the way women interact in intimacy and emotional situations is considered to be better than the way men do. I am not sure that is a correct model: men and women are different, not better or worse.

"To say MDMA gets men to act more like women, and gets women to be even more like the ideal woman, only says this has an effect in some way on the intimacy response. I am not sure this means it is a better way of interacting or whether that way of interacting is different from the way we interact.

"If we assume the male and female way are equivalent, but different, then all we have done is to shift this scale. Another drug could shift the scale more to a male intimacy model."

Opinions vary: users become wholly self-actualized, insightful individuals or nauseated, hyperthermic, catatonic idiots

Ronald Siegel

MDMA

Traditional low profile discarded

Israel turns spotlight on youth anti-drug drive

TEL AVIV — The Israeli Anti-Drug Abuse Association — *Al-Sam* — has launched a nationwide "spotlight" drive among the country's youth.

The move is a break from Al-Sam's traditionally low-profile mould.

This spring, Al-Sam sent 10,000 high school students door-to-door distributing information leaflets and collecting donations for the non-profit, voluntary association founded in 1974.

The campaign was launched with the blessing of the Ministry of Education and Culture, which must approve projects involving school age children.

The funds — the financial goal was set at Cdn $248,000 and contributions from one New Israeli Shekel (93 cents) to NIS 10 were requested — will be used to continue financing the work of Al-Sam. The organization runs five centres for adolescents and is planning to open two more.

The fund-raising came in the face of growing drug abuse problems among Israeli youth.

Moshe Tiomkin, national chairman of Al-Sam and former chief of the Tel Aviv Police District, said a survey five years ago showed 9.4% of all high school seniors, or pre-army service youngsters, had used a drug such as hashish "one or more times." A survey one year ago showed 17% of youths inducted into the army were one time or more users.

Lavana Zamir, national executive director of Al-Sam, told a press conference here "between 100 and 150 people die each year in Israel from 'hard' drugs."

Ms Zamir said there are an estimated 8,000 known addicts in Israel.

And, she said, treatment for these addicts is almost non-existent: the Ministry of Health, "does not even try to wean drug addicts; its sole purpose is to give them Adolan (methadone). The prisons are full of drug addicts who receive no help whatsoever in starting a new life."

The only real effort, she adds, is a "cold-turkey" approach being taken in government psychiatric wards. But, the follow-up process is defective, psychiatric help is sparse, and few people actually remain off drugs for a long time.

Al-Sam tried to fill the gap a year ago. With permission from the Ministry of Health and a $500,000 donation from a United States philanthropist, Al-Sam planned to open a two-year treatment project similar to programs abroad which have had high success rates.

But, residents near the Tira site objected to their neighborhood becoming a "national centre for drug addicts," and the project closed one day after it opened.

Efforts to find another site were unsuccessful.

Recently, the president of Ben Gurion University in Beersheba, offered buildings for the program, if Al-Sam could find another half a million dollars to finance a university drug addiction research department. Efforts to raise the money failed.

Al-Sam decided to "go public with our quiet work," Ms Zamir said, and launched its information and fund-raising drive.

Now, Al-Sam's aim is to convince young people not to take the first puff of hashish.

Ms Zamir believes that while not all users of hashish go on to other drugs, virtually all users start with hashish.

Most of the 520 youth attending Al-Sam's Tel Aviv station in 1985 came not because they were already smoking hashish, but because they believed they had problems which might lead them to do so. Only about 10% remain for help with actual drug problems.

Brown sugar heroin hits Indian streets

TORONTO — Heroin addiction is spreading so quickly in India, officials are unable to keep up with the demand for treatment and rehabilitation.

Addiction to brown sugar heroin or "smack," an impure form of the drug, has hit almost every segment of society. And, hospitals in India's major cities are ill-equipped to deal with the problem.

Three years ago, "hardly anyone had heard of smack addicts;" today it's become the number one addiction problem in the country, says a special report in *India Today*.

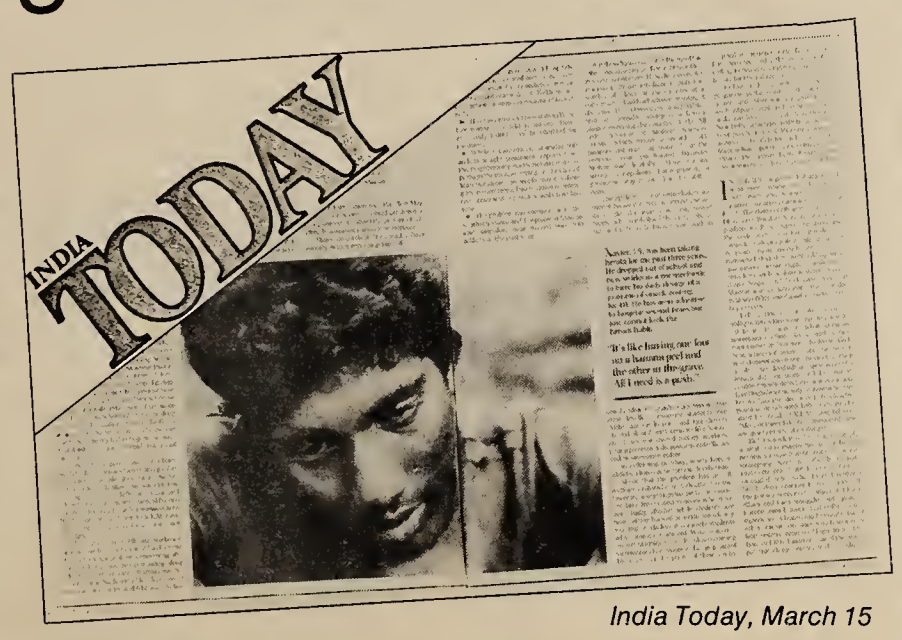
Four major government hospitals in Delhi treated nearly 3,000 addicts last year, turning away 1,000 of them because of lack of beds. In 1982, only 50 addicts were treated.

Similar problems are found in India's other major cities — Bombay, Calcutta, Madras, and Bangalore.

The All-India Institute of Medical Sciences in Delhi treated a record 1,044 patients last year, up from 325 the previous year.

Psychiatrist Davinder Mohan told *India Today*: "What we are seeing is an epidemic that is growing in geometric progression. And, it is still to peak."

Availability of heroin and low prices are blamed for the epidemic.



India Today, March 15

Prices for 25 milligrams of brown sugar heroin dropped to 15 rupees (Cdn $1.66) from 50 rupees (Cdn $5.56) two years ago, making a dose of the drug about the same price as a bottle of beer. One addict commented the heroin was cheaper and more intoxicating than alcohol and had the added advantage that his breath did not smell, so his parents couldn't easily detect his new addiction.

Officials blame the ready availability of heroin on India's position as a major transit centre. Every year, approximately 3,000 kilograms to 5,000 kg of heroin are smuggled from Pakistan's North-West Frontier Province (**The Journal**, April) through the borders of Punjab and Rajasthan destined for Europe.

While use of the drug cuts across social lines, officials are particularly concerned about its use by the young. Hospitals report that at least a quarter of the addicts coming for treatment are in their teens. At one college, counsellors estimate at least 15% of the students have tried smack, with at least 7% becoming regular users.

Facilities for treating addicts are inadequate, says *India Today*. The four government hospitals here have only 40 beds and the majority of the 3,000 addicts admitted last year had to be treated as outpatients. The story is the same elsewhere in the country.

The government has commissioned a survey in the nine major cities to measure the magnitude of the problem and has set up an interministerial group consisting of officials from health, welfare, education, finance, and home departments to formulate a plan to check the spiralling growth.

And, police are stepping up enforcement efforts aimed at traffickers — increasing arrests and adding special squads to deal with the problem.

Women smokers require doctors more often than non-smokers

AUCKLAND, NZ — Women who smoke are more likely than non-smokers to experience illnesses and various symptoms of ill health, a study here indicates.

And, women who smoke are more likely to seek treatment from a general practitioner and to be admitted to hospital.

Not only were symptoms such as morning cough associated with cigarette smoking in the study of 978 women, but also such problems as headaches and indigestion.

Acute or chronic illnesses were also more frequent among smokers than non-smokers, and smokers more often experienced irritability, restlessness, and tiredness.

Smokers in the sample had 16.5% more visits to their general practitioners than non-smokers. If this increased use of health care was typical of all 720,000 smokers in New Zealand, the extra cost of general practitioner visits associated with smoking would be almost $9 million (Cdn $7.25 million) a year, the authors said.

The study was reported by Jane Chetwynd, PhD, community health lecturer at the Christchurch Clinical School of Medicine, and Tony Rayner, professor of economics at Lincoln College, Christchurch, in the *New Zealand Medical Journal* (1986, v.99: 230-2).

Successful detox program depends on patient motivation and selection

TEL AVIV — A medical team at the government-run Eytanim Psychiatric Hospital, high in the Judean Hills, has established a successful, seven-day detoxification plan for alcoholics.

The team admits much of the success stems from four factors: high motivation among subjects, good physical condition, selection and recommendation by a community alcoholic detoxification health centre, and continued treatment and supervision in the same centre at the end of the seven days.

The program is outlined in *Harefuah* (February 2), the scientific journal of the Israel Medical Association.

The team states: "Although Israel has fewer alcoholics than other Western societies, the number is increasing.

"If a survey in 1982 showed 6,000 alcoholics in Israel, today the number is believed to have jumped to 10,000 (out of a population of four million)."

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $24 per year
Air Mail: add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENTS

New Books

by MARGY CHAN

Alcoholism: Its Natural History, Chemistry and General Metabolism

. . . by William J. Haugen Light

The last 10 years or so have seen an enormous growth in alcohol and alcoholism research and a corresponding proliferation of professional and scientific literature scattered in a number of disciplines. Directed primarily to health care professionals — especially medical students, physicians, psychiatrists, and counsellors — this book brings together the substance of this vast literature, organizes it in a coherent way, and translates it into comprehensible English.

This is the first of a five-volume series aimed at providing a synthesis of currently available scientific information. Other volumes are: *The Neurobiology of Alcohol Use; The Psychodynamics of Alcoholism; Alcoholism and Women, Genetics, Fetal Development and Polydrug Abuse; Alcoholism, Co-Dependency, Recovery, and the Role of the Clinician.*

Charles C. Thomas, Springfield, Illinois. 155 p. $24.75. ISBN 0-398-05147-X.

Alcohol Interventions: Historical and Sociocultural Approaches

. . . edited by David L. Strug, S. Priyadarsini, and Merton M. Hyman

(A supplement to Alcoholism Treatment Quarterly Vol 2.)

Written by an interdisciplinary group of researchers, this book presents an historical and sociocultural perspective of contemporary alcoholism interventions and rehabilitation strategies.

A variety of treatment settings, including detoxification centres, halfway houses, outpatient and residential rehabilitation programs, are discussed.

The concluding chapter covers the broader issues of alcoholism treatment, which the authors identify as the dilemmas of propriety, professionalism, and power.

The Haworth Press, New York, NY, 1986. 218 p. ISBN 0-86656-359-8.

Other books

One Step Ahead: Early-intervention Strategies for Adolescent Drug Problems — J.A. Muldoon and J.F. Crowley, 1986. this book covers the essential components of prevention programs designed specifically for young people. It focuses on schools, courts, social service systems, and specialized youth-oriented agencies. Community Intervention Inc, Minneapolis, Minnesota. 179 p. ISBN 0-9613416-1-0.

The Structure of Psychiatry in the Soviet Union — Edward Babayan, in collaboration with Yu G. Shashina, 1985. The book concentrates on the organization and delivery of psychiatric care, and on the jurisdictional, legislative, and legal standards adopted in regard to the mentally ill. It contains hard-to-find biographical material of Soviet psychiatrists, some with photographs. International Universities Press, New York, NY. Index. 336 p. $40. ISBN 0-8236-6169-5.

Potato Chips for Breakfast: An Autobiography — Cynthia Scales, 1986. A young girl struggles to survive in the chaos of a family with two alcoholic parents. Quotidian, Rockaway, New Jersey. 160 p. ISBN 0-934391-05-X.

Projections

The following selected evaluations of audio-visual materials bave been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

12 Steps

Number: 739.
Subject heading: Treatment/rehabilitation.
Time: 35 min.
Synopsis: Many people who have had problems in their lives, for example, alcoholism, gambling, over-eating, have found that by living the 12-Step program, they have been able to recover and live happy, productive lives. People using the program explain what each step means to them and how they use it in their daily lives.
General evaluation: Very good (5.2). The film, although it seemed lengthy, was moving and provided insight into the 12-Step program. Especially noteworthy was the cinematography.
Recommended use: With a resource person, the film could benefit general audiences and people entering treatment.

Detachment with Love

Number: 737.
Subject heading: Alcohol and the family.
Time: 28 min.
Synopsis: A couple enters a meeting hall. While the wife goes to her meeting, the husband reluctantly attends a group for spouses of alcoholics. The lecturer's feelings about her spouse are illustrated by flashbacks from her own experience. She emphasizes that alcoholics must take responsibility for their own actions. At the end, the husband appears to have taken the message to heart.
General Evaluation: Good (4.2). This contemporary film presents the problems of a spouse of an alcoholic very well. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit spouses of alcoholics.

You Could Be the One

Number: 740.
Subject heading: Impaired driving.
Time: 11 min.
Synopsis: Young people are asked what they think makes a good party. Most argue alcohol is a prerequisite. They are then asked if they drive home from these parties, and most agreed that they do. Two couples whose children have been killed by drunk drivers are interviewed. Two young victims of drunk driving tell of their experiences and the consequences: one is now a paraplegic; another had previous impaired-driving convictions but still drove drunk. He lost an eye, seems slightly brain damaged, and appears to be paralyzed.
General evaluation: Good (4.2). The film has emotional impact. General broadcast is recommended.
Recommended use: General audiences.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

6th International Congress of Immunology — July 6-11, Toronto, Ontario. Information: Clarendon Communications, 44 Victoria St, Ste 920, Toronto, ON M5C 1Y2.

Summer School for Addiction Studies — July 7-25, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

27th Annual Institute on Addiction Studies — July 13-18, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

International Conference on the Dynamics of Social Change: Implications for Safety — July 29-Aug 1, Edmonton, Alberta. Information: Conference secretariat, Dynamics of Social Change, 171 Nepean St, Ste 600, Ottawa, Ontario K2P 0B4.

American Hospital Association Annual Meeting — Aug 4-6, Toronto, Ontario. Information: John McMahon, president, 840 N Lakeshore Dr, Chicago, Illinois 60611.

North American Congress on Employee Assistance Programs — Aug 5-8, Toronto, Ontario, Information: Diane Vella, 2154 Crooks Rd, Ste 103, Troy, Michigan 48084.

Canadian Woman's Christian Temperance Union Convention — Aug 11-15, Fredericton, New Brunswick. Information: A.H. Rawlins, Canadian WCTU, 875 Sunset Blvd, Woodstock, Ontario, N4S 4A5.

Canadian Society of Hospital Pharmacists 39th Annual Meeting — Aug 28-30, Ottawa, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

Canadian Society of Forensic Science Annual Conference — Sept 15-19, Niagara Falls, Ontario. Information: Executive secretary, Canadian Society of Forensic Science. 2660 Southvale Cres, Ste 215, Ottawa. ON K1B 4W5.

Fundamental Concepts — Sept 15-19, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

55th Annual Meeting of the Royal College of Physicians and Surgeons of Canada — Sept 21-25, Toronto, Ontario. Information: Pierrette Leonard, communications section, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, ON K1M 1P4.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

Introductory Addictions Management Course — weekly, from Sept 24-Nov 26, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Orientation to Detoxication Services — Sept 29-Oct 3, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Ontario Occupational Health Nurses' Association 1986 Conference — Sept 29-Oct 3, Sudbury, Ontario. Information: J.M. Martindale, publicity chairperson, c/o Inco Ltd, 38 Godrey Dr, PO Box 729, Copper Cliff, ON P0M 1N0.

The Troubled Employee: Intervention in the Workplace — Oct 1-3, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Workplace 86 — Beyond Awareness: Emerging Issues — Oct 1-3, Edmonton, Alberta. Information: Alberta Alcohol and Drug Abuse Commission, community education services, Ste 803, 10109-106 St, Edmonton, AB T5J 3L7.

American Association for Automotive Medicine Annual Meeting — Oct 6-8, Montreal, Quebec. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Addiction and Family Violence — Oct 18, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Social Science Federation of Canada Research 86: Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario K1A 0N5.

Building Effective Employee Assistance Programs: Employee Benefit and Productivity Tools — Oct 29-30, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4R5.

Event 86 — Skill Development and Training for Employee Assistance Personnel — Nov 16-20, Oakville, Ontario. Information: James Simon, Addiction Research Foundation, Georgian Bay Centre, PO Box 936, 100 Bell Farm Rd, Barrie, ON L4M 4Y6.

Drug Education Coordinating Council 4th Annual Conference — Nov 20-21, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

The Community and Northern Justice — March 15-20, 1987, Whitehorse, Yukon. Information: Northern Conference Office, c/o continuing studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

United States

15th Annual San Diego Summer School of Alcohol and Other Drug Studies — July 6-11, San Diego, California. Information: University of California, San Diego X-001, La Jolla, CA 92093.

17th Annual Narcotic Research Conference — July 6-11, San Francisco, California. Information: E.L. Way, department of pharmacology, University of California, San Francisco, CA 94143.

Adolescents and Chemical Dependency: Effective School Programs — July 7-11, Detroit, Michigan. Information: Maryann Allen, Fairlane Health Services Corp, 31780 Telegraph Rd, Ste 200, Birmingham, MI 48010.

How to Set Up a Student Assistance Program — July 7-11, Baton Rouge, Louisiana; July 14-18, Manchester, Connecticut; Aug 4-8, Seaside, Oregon; Aug 11-15, Seattle, Washington; Aug 18-22, Center City, Minnesota. Information: Hazelden Health Promotion Services, 1400 Park Ave S, Minneapolis, MN 55404.

When Chemicals Come to School: Core Group Training for Student Assistance Programs — July 14-18, Milwaukee, Wisconsin. Information: De Paul Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

Effective Counselling of Chemically Dependent Youth — July 15-17, Louisville, Kentucky. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

Older Adults and Chemical Health — July 17-18, St Paul, Minnesota. Information: Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

Street Drugs: Evolution of Current Trends and Overview of Treatment Models — July 19, Oakland, California. Information: Stephanie Ross, training coordinator, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

Intervention: How to Help Those Who Don't Want Help — July 22-24, Washington, DC; Sept 23-25, New York, NY; Oct 7-9, Atlanta, Georgia; Oct 21-23, New Orleans, Louisiana. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

New Jersey Summer School of Alcohol and Drug Studies — July 27-August 1, New Brunswick, New Jersey. Information: Center of Alcohol Studies, Rutgers University, Smithers Hall, Piscataway, NJ 08854.

Addictions: Weaving the Common Thread, 1st Southwest Institute on Alcohol and Drug Abuse —July 27-Aug 1, Austin, Texas. Information: Judee Arkow, 1705 Guadalupe, Austin, TX, 78701-1214.

Children of Alcoholics: Northwest Region III — Aug 1-3, Seattle, Washington. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

1st National Conference on Alcohol and Drug Abuse Prevention: Sharing Knowledge for Action — Aug 3-6, Washington, DC. Information: Teddi Pensinger, National Institute on Alcohol Abuse and Alcoholism, prevention branch, 16-C-14, 5600 Fishers Ln, Rockville, Maryland 20857.

Chemical Dependency Nursing — Aug 4-15, San Diego, California. Information: University of California, San Diego, X-001, La Jolla, CA 92093.

Effective Assessment of Chemically Dependent Youth — Aug 5-7, Buffalo, New York. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

Annual Conference International Doctors in Alcoholics Anonymous — Aug 7-10, San Diego, California. Information: Lewis K. Reed, 1950 Volney Rd, Youngstown, Ohio 44511.

9th Annual North Carolina School for Alcohol and Drug Studies — Aug 11-15, Wilmington, North Carolina. Information: Office of special programs, University of North Carolina, 601 S College Rd, Wilmington, NC 28403-3297.

Midwest Conference on Alcoholism and the Family — Aug 17-21, Minneapolis, Minnesota. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

26th Annual Southeastern School of Alcohol and Drug Studies — Aug 17-22, Athens, Georgia. Information: Bill Johns, Georgia Center for Continuing Education, University of Georgia, Athens, GA 30602.

Assessing Adolescent Drug Abuse in the School Setting: Concepts, Tools, and Skills — Aug 19-21, Milwaukee, Wisconsin. Information: De Paul Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

1986 Illinois Institute on Drugs and Alcohol — Aug 24-28, St Charles, Illinois. Information: Emma Redmond, State of Illinois Center, 100 W Randolph, Ste 5-600, Chicago, IL 60601.

North American Congress on Alcohol and Drug Problems — Sept 7-11, Boston, Massachusetts. Information: Alcohol and Drug Problems Association, 444 N Capitol St NW, Ste 181, Washington, DC 20001.

Children of Alcoholics — Sept 25-27, Chattanooga, Tennessee; Oct 16-18, Phoenix, Arizona; Nov 6-8, Houston, Texas; Nov 13-16, Los Angeles, California. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Alcohol-Related Birth Defects: Implications for Policy— Oct 19-21, San Diego, California. Information: Alcohol-Related Birth Defects Conference, University of California, San Diego X-001, La Jolla, CA 92093.

Northeast Conference on Addictions: The Chemically Dependent Family — Oct 26-29, Albany, New York. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Improve Your Group Counselling: An Advanced Skill Building Seminar — Oct 28-30, Houston, Texas. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Nov 3-6, Dallas, Texas. Information: Judith Evans, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Effective Counselling of Chemically Dependent Families — Nov 11-13, Washington, DC. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

American Association for Advancement of Behavior Therapy Annual Meeting — Nov 13-16, Chicago, Illinois. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

14th Annual Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Nov 17-21, Boston, Massachusetts. Information: Kristine Niven, administrative associate, Center for the Study of Drug Development, Tufts University, 136 Harrison Ave, Boston, MA 02111.

SECAD XI: Southeastern Conference on Alcohol and Drug Abuse — Dec 3-7, Atlanta, Georgia. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, 11050 Crabapple Rd, Ste D-120, Roswell, GA 30075.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, 1987, Orlando, Florida. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Alcohol Problems in the Workplace: Beyond Employee Assistance — June, 1987, La Jolla, California. Information: Tom Colthurst, Program on Alcohol Issues, University of California, San Diego, X-001, La Jolla, CA 92093.

Abroad

International Symposium on Health Education in Schools —July 6-10, Jerusalem, Israel. Information: D. Tamir, international symposium, PO Box 394, Tel Aviv 61003 Israel.

Psychiatry and its Related Disciplines: The Next 25 Years — Aug 12-22, Copenhagen, Denmark. Information: DIS Congress Service, Linde Allé 48, DK-2720 Vanlose/Copenhagen.

14th International Cancer Congress — Aug 21-27, Budapest, Hungary. Information: Crimson Travel Service, 39 John F. Kennedy St, Cambridge, Massachusetts 02138.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

10th World Conference of Therapeutic Communities — Sept 7-12, Eskilstuna, Sweden. Information: The United Swedish Foundations, Box 354, S-641, 23 Katrineholm, Sweden.

10th International Conference on Alcohol, Drugs, and Traffic Safety — Sept 9-12, Amsterdam, The Netherlands. Information: Symposium secretariat, QLT, convention services, Keizersgraacht 792, NL-1017 EC Amsterdam.

International Symposium on Young Drivers' Alcohol- and Drug-Impairment: Selective Countermeasure Program Development — Sept 13-15, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, dept of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

International Conference on Addiction — Oct 19-24, Vienna, Austria. Information: Barbara Turner, conference coordinator, Bldg D, Ste 120, 11050 Crabapple Rd, Roswell, Georgia 30075.

Alcohol Problems in Celtic Countries — Oct 30-Nov 2, St Peter Port, Guernsey, Channel Islands. Information: P.J. Lemmon, Guernsey Council on Alcoholism, 50 The Bordage, St Peter Port, Guernsey, Channel Islands.

Society for Prevention of Drug Abuse 1st Scientific Congress: Problems of Drug Addiction —Nov 3-4, Warsaw, Poland. Information: Congress organization committee, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warszawa, Poland.

11th World Congress for Social Psychiatry — Nov 6-11, Rio de Janeiro, Brazil. Information: J. Alberto Costa e Silva, Faculdado de Ceincias Médicas, Hospital de Clinicas, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil.

7th International Conference on Alcohol Problems — April 5-10, 1987, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

'Some of society's assumptions are bizarre'

Rock's role in drugs

By Mark Kearney

TORONTO — The audience heard rock songs — *Smuggler's Blues*, *Love is a Drug*, and *I Want a New Drug*.

They also heard that rock and roll has been handed a bad rap for its part in influencing drug use and abuse among teenagers. And, that the rock music industry has cleaned up its image and is acting with more of a social conscience than ever.

Rock's role in drug use: myth or reality? was the question posed at a public forum sponsored by the Addiction Research Foundation here. "Myth" was the loud and clear answer from the panel of experts discussing the issue.

Said Christoper Ward, a 'veejay' at MuchMusic, Canada's rock video television station: "I think of drugs and rock and roll as being a fairly non-issue these days.

"Although rock and roll may be a backdrop for various people's excesses, I don't personally believe it encourages or condones that kind of behavior."

The panelists agreed drug use does occur in the rock music industry, just as it does in others, but said the link between music and drugs was more of a factor in the 1960s, when illicit drug use was still relatively uncommon.

They mentioned rock musicians speaking out against drinking and driving on radio and television and the music industry's efforts to help feed people in Africa through such projects as Live Aid, as examples of rock's renewed commitment to bettering society.

Hard rocker Lee Aaron was one panelist: "I'm a firm believer rock and roll has very little to do with drug addiction." While acknowledging there are musicians who do use drugs, she said: "I'm here today (as a successful musician) because I'm not a drug user, and I don't allow it within my organization."

Most people in the music business today stay away from drugs and don't even want to work with people who are users, Ms Aaron said.

Furthermore, the powerful medium of rock videos has a tempering influence on rock stars' involvement with drugs, she added.

"Entertainers are being a lot more careful of the image they are presenting to young people. I know I'm a role model."

Rob Quartly, a director of music videos with Champagne Pictures in Toronto, agreed; the performers he works with stay away from drugs because of the potential damage use can have on a career.

"Everyone these days is keenly aware of how powerful the image is; they're more concerned about their image." He added that many bands couldn't physically manage the rigors of performing and recording if they weren't in good shape.

Quiet Riot: telling you to party, not go home and read Emily Dickinson

Rock musician and panelist Ian Thomas echoed his peers' views, but said despite the changing image of rock performers, there is still a stigma linking the music with drug use.

He cited as an example the rock band, Rush, whose members are "the most health conscious people I know."

Nevertheless, he said, there are people who still make this "kind of bizarre assumption that these people (Rush) must be on something, to make music like that."

Jonathan Freedman, PhD, psychology professor at the University of Toronto, likened the stigma to one attached to violence on TV. He said people tend to blame TV for violence in society even though the scientific literature doesn't support that belief. The same kind of blame is focused on rock music.

"It may sound plausible (to link rock music with drug use)," he said. "But, just don't assume that because it sounds like it might be true, it is true. It probably isn't."

Dr Freedman argued rock musicians are scapegoats in discussions about drug abuse among teenagers. In fact, abuse is more likely a larger societal problem that is difficult to solve.

"It's tougher to change society. So people say, 'Well, we can't do anything about that, so let's blame it on rock and roll, which we don't like.' "

Ron Clavier, PhD, a psychologist at the Clarke Institute of Psychiatry here and moderator of the forum, concurred music is a natural scapegoat because it is an important part of a teenager's life.

"As part of teenagers' search for independence, it becomes very important for them to find something that's their own," he said. "Fashion and music are the legacy of every generation. You can identify the generation by the music they listen to and the clothes they wear."

Mr Thomas argued that the link between rock music and drugs could be more than an attempt to find a scapegoat.

"A lot of rock and roll does support rebelliousness. Rebelliousness does support: 'Let's party, let's get reckless.' And, sometimes this is where people find themselves falling victim to dope.

"So, to say rock and roll is completely clean of any connection with dope . . . well, there are some connections that can be made.

"The problem is that most of the people playing rock and roll aren't saying you have to be a dope addict to be rebellious. You can be rebellious in a positive sense."

Mr Ward agreed it's rock's nature to be fun and sing songs about having a good time. That doesn't mean there's a message to use drugs.

"(Rock band) Quiet Riot aren't going to write a song telling you to go home and lie down and read Emily Dickinson," he said. "They're going to tell you to party. That's what rock and roll is all about."

But, does drug use heighten a performer's creativity?

The panelists agreed some performers, as well as novelists, poets, and philosophers, have used drugs in pursuit of their art. In the long run, however, they usually suffer for it."

Mr Ward: "Some people like to get high to create; that's a fact of life. That's an individual choice. I think the important thing is they don't go out and glorify that."

Added Ms Aaron: "I wouldn't dare walk on stage in that state of mind or sit down and write a song. I want to be in control of what I do."

She said the impression she gets from her teenage fans is that most of them are aware rock and roll and drugs don't go hand in hand.

"It's becoming more and more of a non-cool thing to do drugs among young people today," Ms Aaron noted. "Many kids get high on the music. Rock and roll is healthy escapism. It's not bad for your health."

Mr Thomas also suggested most teenagers know enough to stay away from drugs.

"I can't see someone saying, 'Just because someone (a rock musician) does it, it's okay for me to do it.'

"Anybody who can make a statement like that is a mental midget," he said.

THE BACK PAGE

Thomas

Freedman

Quartly

Aaron

Ward

Clavier

Conference coverage pages 7-8

HELSINKI

3rd Congress of the International Society for Biomedical Research on Alcoholism

Advances limited in biomedical research

By Harvey McConnell

HELSINKI — Progress in biomedical research on alcohol has often depended on chance developments in technology and thus has been erratic, says Harold Kalant, MD, PhD.

Dr Kalant told the 3rd Congress here of the International Society for Biomedical Research on Alcoholism, in biomedical research, as in other types of specific laboratory research, progress has depended on "methods that make it possible to answer the questions it was not previously possible to answer.

"In that sense, progress has been, and continues to be, somewhat erratic: rapid progress in one area, and then it will stop for a while; suddenly, there will be progress in another area."

There are limits on advances, therefore, and problems that remain, said Dr Kalant, director of biobehavioral research at the Addiction Research Foundation, Toronto, and professor of pharmacology at the University of Toronto.

Dr Kalant pointed out several major questions, which do not change from year to year and do not depend on methodology, he would like to see answered in relation to alcohol:

- what mechanisms underlie the acute effects of alcohol on the first exposure of a person to the consumption of alcohol;
- why and how some of those effects are aversive and decrease the likelihood of drinking again, while other effects produce reinforcement and increase the likelihood of renewed ingestion;
- how repeated ingestion changes the pattern of effects not only by repetition of reinforcement, but also by production of tolerance and physical dependence; and,
- why tolerance has up to now been evident only in relation to aversive effects and not to reinforcement; how physical dependence modifies the subsequent course of drinking behavior; and, what determines when repeated ingestion of alcohol in certain amounts leads to, or modifies, the occurence of organic disease in different ways.

Dr Kalant said there have been a number of findings in the relationship between genetics and alcoholism, and out of these has grown the concept that familial al-

(See Geneties, p2)

Vol. 15 No. 8 2nd Class Mail Reg No. 2776 TORONTO, August 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

The Kabay Diary

The story of a pioneer scientist couple

The centre section

Cocaine problem far larger in US

'Crack' threat to Canada being overplayed

By Anne MacLennan
Editor

TORONTO — Despite alarm bells of publicity here about the crack "epidemic" sweeping from east to west across the United States, Canada may well escape serious crack problems.

Nationwide data on crack in Canada are non-existent; but, expert trend-spotters, while extremely concerned, are tentatively optimistic.

They are concerned because the cocaine freebase product, also called "rock," is cheap, easy to make and use, highly potent, and highly addictive. These factors combined have created what US experts say is a major new cocaine problem among US adolescents.

Furthermore, experience repeatedly shows that US drug fads almost inevitably slip across the border into Canada.

Collectively, however, observers say there are more reasons for optimism than pessimism.

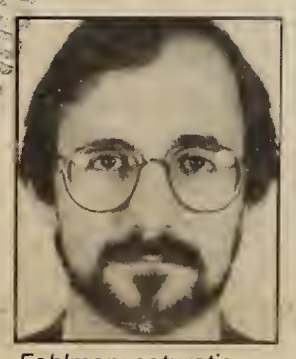
Chief Superintendent Rodney T. Stamler, director, Drug Enforcement Directorate, RCMP (Royal Canadian Mounted Police), is a shrewd observer-of-both national and international drug trends.

"Concern about crack is appropriate. Smoking it can become a lifestyle very quickly," he says.

"Certainly, it has the potential to become a popular way to use coke. But, it's the extent to which it will catch on here that is the question.

"Cocaine has always been a significantly larger problem in the US than in Canada — whether cocaine hydrochloride or freebase. From the enforcement perspective, we have still only had a couple of incidents in terms of crack."

Stamler: potential



Fahlman: saturation

Adamson: ready

Robert Fahlman, chief of strategic analysis and publications for the Drug Directorate: "Canada may be getting close to the saturation point with cocaine. Our 1985 data indicate the amounts of cocaine coming in seem to be levelling off. Even our most recent data aren't showing significant increases in activity."

And, he says, Canadian users are more conservative than those in the US. Nor is there the same degree of experimental use here.

"Partly, that has to do with the size of the population. Partly, it has to do with our different culture."

Mr Fahlman likened crack to PCP (phencyclidine): "There was widespread alarm in the North American media about PCP, but we had nowhere near the extent of abuse here in Canada they had in the US."

Laurie Adamson is chief analyst in the street drug analysis section of the Addiction Research Foundation (ARF) Drug Analysis Laboratory, one of the foremost of its kind.

When reports about crack began to spill into Canada, she "battened down the hatches. I was going to be ready." Many of her contacts and associates did the same thing.

(See Freebasing, p2)

Coca paste could replace crack in the US

The Back Page

AIDS is up among European IV drug users

By Kate Fournis

PARIS — The most significant increase in European AIDS (acquired immune deficiency syndrome) cases is being seen in intravenous (IV) drug users, the Second International Conference on AIDS was told here.

But, cases among addicts represent a lower proportion of total cases in Europe than in the United States, said Jean-Baptiste Brunet, MD, coordinator of the World Health Organization's European AIDS monitoring program. The European total was 10%, compared to 17% in the US, as of quarterly reports submitted to the WHO in March by 26 countries.

(At that time, there were 2,542 AIDS cases reported from Europe, and more than 21,000 from the US.)

The increase among European addicts is particularly marked, rising to its current level from 2% of all European cases as of October, 1984.

The situation is particularly true in southern Europe. When the WHO European Collaborating Centre on AIDS released its figures for the reporting period ended last September, Spain and Italy together accounted for 63% of all European IV drug addict cases. The most current figures (March, 1986) show addicts now represent almost 50% of reported cases in those two countries.

Drug addicts in most European capitals are also showing a high rate of antibody development to human immunodeficiency virus (HIV), the agent that causes AIDS, Dr Brunet explained. (HIV is the new, standard designation for the AIDS virus, proposed by the International Committee for the Taxonomy of Viruses and recognized here at the International Conference on AIDS. It has been called HTLV III, particularly in the United States.)

Addict populations studied in Italy, Spain, and Switzerland have rapidly reached high levels of antibody-positivity. Research shows an increase in percentages of addicts infected in Italy to 76% in 1985 from 6% in 1980; in Spain, to 48% in 1985 from 11% in 1983; and, in Switzerland, to 37% in 1985 from 16% in 1982.

Studies in France this year have shown up to 70% of addicts infected; in Austria, the rate is around 30%.

Although Eastern Europe is considered to be in a pre-epidemic phase, a recent study of 496 addicts in Yugoslavia showed 165, or 33%, were infected.

Infection with HIV doesn't always produce AIDS, but one study of homosexual men in San Francisco suggests 30% of those infected may develop AIDS within six years.

While he did not provide information on risk groups in Asia, Dr Brunet noted the prevalence of cases there is low and that public awareness may buy time and check the disease's spread.

Reporting from some areas may be incomplete, but a total of 49 cases have been reported from 11 Asian countries, including one from China, three from Hong Kong, six from Thailand, and 14 from Japan.

In Alberta and Manitoba

Agency officials announced

Appointments have been made to executive positions at both the Alberta Alcohol and Drug Abuse Commission (AADAC) and the Alcoholism Foundation of Manitoba (AFM).

Stevens: AADAC

Puchlik: AFM

Greg Stevens, former Alberta minister of personnel, has been named chairman of AADAC, and Ian Puchlik is the new executive director at AFM.

Mr Stevens, the MLA (member of legislative assembly) for Banff-Cochrane since 1979, says he is "very excited to be a part of AADAC because it is such a positive organization."

A professional engineer, Mr Stevens had been vice-president of the Alberta Housing Corporation. He is a past chairman of the Banff social planning committee.

Mr Puchlik, a certified management accountant, has been with the AFM since 1975. He has been director of support services, responsible for the day-to-day management of the foundation.

INSIDE

NEWS

Briefly ...

Grey haze fazed out

TORONTO — Gray Coaeh bus eompany travellers must now butt out their eigarettes before boarding the buses, whieh earry three million people a year between eities. The eompany began the poliey in June and hopes even smokers will be supportive, says *The Toronto Star*. President Bill Verrier says "it's an idea whose time has come .... I don't think there'll be a mass exodus from our serviee."

Bar and drill

LANSING, Michigan — California dentists are attempting to soothe nervous patients by serving free wine in their waiting rooms, says *Monday Morning Report*. The move by dentists is an attempt to find more patients, because of a declining workload. One dentist in Marin, California, Dr Joseph Armel, has tagged his practiee Joe's Bar and Drill.

Saving the bacon

HANNOVER — Louise, the world's only drug-sniffing pig is back on duty following her suspension when West German police decided she was bad for the force's image. But, the pig was saved from the baeon faetory by the Green Party and now carries the initials SWS after her name, says *Reuter*. SWS? It's short for *schnueffelwildschwein*, German for tracker pig.

Apartheid squeeze

WINNIPEG — Although South African wines and brandies have been pulled off shelves here to protest apartheid, the Manitoba government has come up with another way to renounce raeism. Attorney-General Roland Penner has announeed that $570,000 worth of South African wines and brandies will be put on sale again, with profits going to the Manitoba Coalition Against Apartheid.

Say no, say yes

WASHINGTON — The National Council on Alcoholism (NCA) in the United States has developed a new educational campaign for teens with the theme: "Say no. And say yes to your life." The multimedia campaign was devised by a major New York city advertising agency and is an attempt by the NCA to focus on prevention, says *The Alcoholism Report*.

Racial bias

LANSING, Michigan — Urine tests to detect drugs have a built-in racial bias, says an Atlanta chemist who has spent more than a decade studying various methods of drug testing. Dr John Woodford says dark skin pigment, known as melanin, is frequently mistaken for marijuana residue. Furthermore, other factors can show false-positive results, he says in *Monday Morning Report*. Tonic water consumption can yield a false-positive result for cocaine, and poppy seeds used in pastries result in a false-positive for heroin.

Schools should be smoke-free zones by next autumn, say Ontario doctors

By Betty Lou Lee

TORONTO — Ontario's doctors want the province's elementary schools to be smoke-free by September, 1987, and that includes teachers' lounges.

The Ontario Medical Association's (OMA) general council decided at its annual meeting here to ask teacher, trustee, and parent-teacher groups, as well as the ministries of health and education, to work toward the goal.

The OMA committee on public health, noting that smoking, and environmental tobacco smoke, are "the most preventable cause of morbidity and mortality in the developed world," said very few people start smoking as adults: the habit starts in primary school.

Known factors influential in preventing children from starting are peer groups, examples by parents and teachers, repeated physician advice, and television anti-smoking programs and messages, the committee said.

The OMA also wants its members to give "firm advice to quit smoking" to patients who do, and to work harder for smoke-free hospitals.

As well, the council endorsed a statement that it is unethical for a doctor to prescribe or provide substances banned by the International Athletic Committee solely to aid athletic performance or ability, or to use techniques involving physiologic substances designed to enhance performance (**The Journal**, September, 1985).

The latter would cover situations such as blood doping (removal of a litre of blood about a month before competition, keeping the red cells in frozen storage, and reinfusing them before a meet to increase the oxygen-carrying capacity of the blood) and growth hormone use.

That's the story from California

Freebasing sets stage for 'crack' use

(from page 1)

In terms of demand on the laboratory, she feared crack might equal Paraquat (**The Journal**, October, 1983). When the herbicide was being sprayed on marijuana, "we were flooded with samples — all of them allegedly laced with Paraquat."

But, to date, she has received "nothing even suggestive of crack. Nothing."

Ms Adamson allows her lab samples are biased: "Usually we see drugs that have caused someone problems. To begin with, we never have seen a lot of cocaine. It's the same with heroin. Users of cocaine and heroin are secure in their drugs, in their dealers; unless it causes a problem, we don't hear about it.

"But, with crack, considering the obvious risks and dangers, we should have seen it and we haven't.

"I don't want to suggest it's not out there, but I think the fact we haven't seen it is fairly indicative that it's not there in quantity."

She says while rumors abound about the new drug fad — including one that there's a "crack house" culture in Toronto — the network of official and unofficial intelligence tracking such developments is finding very little evidence.

In San Francisco, David Smith, MD, founder and medical director of the Haight-Ashbury Free Medical Clinics, is watching with alarm as crack abuse moves westward. Although there has been an increase in use in California, particularly among adolescents, the problem is still not as massive in the west as in the east, particularly New York and New Jersey.

Dr Smith says the problem is extremely serious in the US, and Canada is in some jeopardy.

However, he also notes that a key indicator of potential for crack abuse is a large population of freebase users.

While crack is neither difficult nor dangerous to make, the Californian-style method of making freebase involves the use of highly inflammable solvents and is dangerous.

Smith: massive

Adrian: fluctuating

Martin: impressions

Says Dr Smith: "California has had a big freebase problem for a long time; that sets the stage for crack. If freebasing never really caught on in Canada, crack may not."

Although survey questions here tend to ask about cocaine (and not separate out freebase), the consensus among experts is that within the still relatively contained population of cocaine users, the freebasing population is small. (In 1984, 3.3% of Ontario adults — which would correspond to about half a million adults in Canada — had used any form of cocaine at least once in their lifetime.)

Mim Landry, an associate of Dr Smith's at Haight-Ashbury, says there are three main indicators of increased crack abuse: increased cocaine-related admissions to emergency departments, and to treatment, and cocaine mentions in coroners' reports.

In the US, all of these figures are up, and that points to crack, says Mr Landry. "Crack is extremely dangerous; the extremely rapid rise in cocaine blood levels that it provokes are life-threatening." (See Heart, p5.)

In Canada, no such data are available nationwide. Again, however, there are "gut feelings" and indicators.

Toronto, the highly populated core of southeast Ontario, is so far the main hot spot for Canadian cocaine use and enforcement activity. Even here, cocaine figures are low.

As head of socio-behavioral treatment services in the ARF's Clinical Institute, Garth Martin is in touch with front-line treatment trends.

Mr Martin: "While the numbers of cocaine users continue to rise slightly, my impression all along has been that cocaine has never really taken off in Canada. Maybe by the time it got here, it wasn't quite as glamorous. We still see more marijuana problems."

He says the few rock users seen over the last two or three months tend to be regular cocaine users. And, importantly, they make the rock themselves.

"A major fear about rock or crack seems to be that, because it's cheap, dealers will be selling to more young people," he says.

"But, it isn't cheaper, it's smaller quantities. And, there just isn't any evidence at all that it is being made and sold."

Manuella Adrian, chief of the ARF statistical research program, says patients entering the Clinical Institute for alcohol and other drug abuse problems are asked to rank their first, second, third, and fourth problem substances.

Comparing the first three months of 1985 with the first three months of 1986, the total number of people identifying cocaine as their most serious problem substance (crack is not separated out), rose to 89 from 60 people.

Ms Adrian: "It's an increase, but a slight one. In absolute terms, these are relatively small numbers, and small numbers are liable to fluctuation month to month."

She says the number of people identifying cocaine as any kind of problem — major or minor — in the same period rose only very slightly.

One of many rumors in Toronto is that there's crack in Yorkville, a core of fast-lane, middle- and upper-middle class life in the downtown.

An observer agrees it's possible. "There are Russian Roulette players in any crowd."

Genetics of reinforcement a challenge to scientists

(from page 1)

coholism is a genetically determined disease. The pattern is much more marked where there are strong, positive, family histories of first degree relatives with alcoholism.

The question remains, however, what is inherited, and this is still by no means answered fully.

"The real challenge, I believe, remains to develop genetic models which will help us determine what turns on the desire to drink, what turns off the desire to drink. What, in other words, are the genetics of the reinforcement mechanism."

Dr Kalant: "The arbitrary separation of psychological and pharmacological approaches to tolerance is no longer tenable. Future research must be able to account for reactions between these sets of factors in order to come up with satisfactory explanations of the phenomena of tolerance and probably of the associated phenomena of physical dependence."

Resolutions of contradictions and satisfactory explanations of the molecular basis of alcohol's action, and tolerance to them, will probably require new methods for a more sophisticated analysis of lipid changes in the micro-environ-

Kalant: predictions

ment of individual protein structures such as ion channels and receptors.

At the request of conference organizers, Dr Kalant made some predictions about what might happen in the next decade, although he said it would be foolhardy to predict exactly.

However, one area in which technical advances are almost foreseeable is re-examination of the role of neurotransmitters in the nervous system, in relation to the actions of alcohol and the development of tolerance. One possible advance is development of microelectrodes specific for individual transmittors. (See pp 7,8.)

NEWS

It's 'an important form of entertainment' for kids

Winnipeg solvent sniffers receiving little aid

WINNIPEG — Children as young as five years are sniffing solvents here. And, little action is being taken to deal with the problem, two University of Manitoba researchers say.

A study by social work professors Brad McKenzie and Len Kaminski was commissioned by North West Child and Family Services (NWCFS), the largest child welfare agency in Winnipeg. It involved interviews with 38 people in the social services field, including social workers and school officials, as well as young sniffers.

No one group or agency seems willing to undertake a comprehensive program to deal with the problem, the researchers say.

"There was also evidence of a general lack of awareness about many existing programs and evidence of suspicion about some services."

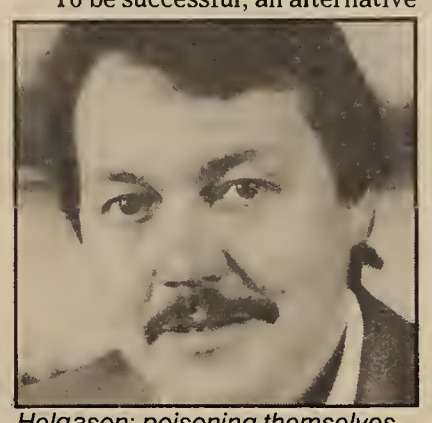
Sniffing was documented as a problem by teachers in inner-city classrooms. In one case, the researchers observed a student sniffing a felt pen during class.

The average age of most sniffers was nine to 12 years, although cases of five- and six-year-old sniffers were recorded.

The professors suggest children begin with solvent abuse and, as they grow older and obtain more money, switch to "more expensive highs — alcohol and drugs."

Young people sniff, the study indicates, because it is "an important form of entertainment. It does represent a cheap high and an antidote to boredom and alienation.

"To be successful, an alternative to solvent use must provide a comparable source of enjoyment, pleasure, and meaning to the lives of users."



Helgason: poisoning themselves

The authors say more health professionals need to be involved in battling the sniffing problem, as well as in providing more social services and recreational activities for inner-city children.

The study is the first to document fully, assess, and say what's needed to combat the problem, said Wayne Helgason, a NWCFS supervisor and a member of Winnipeg's Anti-Sniff Coalition (The Journal, January, 1985).

Mr Helgason: "Essentially, these children are poisoning themselves. I don't think there's any question they are being drastically damaged by this . . . . The education system has a real problem with these kids."

The problem is not a new one. Mr Helgason said his agency had to take in three young children because their parents "were all sniffed-up" and the children were being neglected.

As a result of the study, NWCFS is attempting to set up a comprehensive system involving health workers and representatives from the school to deal with the problem.

Mr Helgason said a clinic with an assessment unit and health counselling would go a long way to helping sniffers. As well, more drop-in centres are needed to compete with sniffing as a recreational activity.

"Over the last decade, we've had a significant problem that professionals have not been able to deal with . . . . I think this problem has been number two on too many agendas for too long.

"Sometimes it takes a tragic event to trigger public awareness."

Golobitsh

Children who sniff: tragic events sometimes trigger public awareness

Sniffing supplies used as payment for sexual favors of youngsters

WINNIPEG — Children here are being lured to trade sexual favors for sniffing solvents.

Recently, a Winnipeg man faced several charges of gross indecency and sexual assault after it was alleged he offered to exchange sniffing products for sexual favors from three young girls.

The problem is serious, said Wayne Helgason, a supervisor with North West Child and Family Services, Winnipeg's largest child welfare agency.

In many cases, the adults involved are known to some agencies. But, he said the children are coerced into the situation and threatened with harm if they tell.

The man charged was one of several whose car licence plate numbers were posted on bulletin boards in community centres in the inner-city area.

Children lured into such situations become doubly victimized because they have a sniffing problem and are then faced with the trauma of being sexually abused, Mr Helgason said.

In one case, a young boy was the victim of abuse by an older man for a year. Several agencies had little success in rehabilitating the boy.

Mr Helgason also said many times the perpetrators aim for children older than 14 years because, if they agree, the adult cannot be charged.

More efforts to offer young street kids an alternative to sniffing as a recreational habit would help, he added.

INSIDE OUT

Hours after the 'big crash'

Wasted chances, missed connections, buried dreams — we find them all

You know how sometimes you're amazed suddenly to find again all those things you'd forgotten about in your life, just as you're getting ready to move?

Yes, rooting in cardboard boxes stashed in cupboards and trying to figure out what to keep and what to discard is like giving yourself a report card. The stuff you unearth from beneath old newspapers and odd pairs of socks and torn record album covers is akin, I think, to an archaeological dig straight into your soul.

Some of the items you stare at in the light in the bedroom bring back deep, sharp pain: letters containing promises from someone to you that are later broken; pictures of people you let down because you lacked bravery, or love; lists of sky-high, impossible goals written out in a passion so fevered that, if you ever really reached them, it would bring you a happiness so complete you'd die instantly in a glorious, cosmic swoon.

Wasted chances; missed connections; buried dreams. We find them all, just before moving day, if we look carefully.

And we discover, once in a while, great times too, coming back to us from the things we own. Magic days and hours that come flying back to us, times when we acted well, generously, decently. With a sense of honor . . . .

So there I found myself recently, moving out again. I expected few surprises from my foraging. I had thrown away almost all of the good and the bad things a few years earlier, back in a time when I vowed to keep on going ahead without the baggage of the past bringing me down. I thought if an event, or a person, is powerful enough, the memory will stay nestled in the mind long after the material things that surrounded it were dropped by the wayside.

But, there they were, on this recent move: three pages ripped from a stenographer's notepad, written in a semi-scrawl, folded in four, underneath an old phone book on the kitchen floor, near the stove.

I had to look hard to make out what was written on them. Initially, I thought the notes were instructions to myself about the logistics of the previous move I'd made, more than a year ago. Instead, I realized, with a little shock, that those pages were my feeble efforts at keeping a journal while I was in the hospital. I'd been sent there by an ambulance following a seizure caused by my alcoholism.

Now, I'd looked at those notes once after I'd been released from the ward and just before my rehabilitation had been set into motion. I remember when I looked at them that one time, I had done so not very carefully at all. To tell the truth, I was slightly afraid of examining them closely. I was still in the stages of continuing to deny that massive crisis in my life; I was thinking, madly, that what had happened to me was somehow not final, not a major turning point after all.

But now, as I looked at them for the second time, I did so with no hesitation. I had shakily triumphed since I had written them in the hospital; I knew that. I wasn't afraid now. I was, in fact, curious to try to see the state of mind I was in when I took up the pen on the bed in that ward.

Here's some of what I wrote, hours after my Big Crash occurred:

"The door seems open everywhere, even to the adjoining bathrooms between some of the rooms . . . . A six-foot wire is fastened to the top sheet by a rubber band and a safety pin. Stretchers go by, nurses and aides run back and forth. Cries of 'Nurse! Nurse!'

"Here," I wrote as I lay on that stretcher in the hallway before I got a room, "is where you have been taken by your friends . . . . Time is all screwed up."

(I remember now that terrible loneliness as I waited in the hall; I felt certain I was going to die that night, and no one would be with me. I was so despairing. I remember too that I couldn't even pray. I know now I was writing this journal because I thought it might be the last thing I was ever allowed to do.)

"Dr coming into the room now, with others in tow," I wrote the next day when I got a room. "Three check-ups in a row, one with a bulky contraption that can barely fit inside the door . . . . They work like Trojans here. Five pills this time! Still waiting for the EEG (electroencephalogram). Supposedly the last test. It's like *One Flew Over the Cuckoo's Nest.*"

Later: "I'm beginning to feel down again, having fantasies of being Cardinal Mindzenty under house arrest in Poland, or wherever, years ago."

The tests went on: "I've been prodded, needled, etc. I brought here what I came in with; a shirt, pants, shoes, socks, and overcoat. That's it . . . . Friends urging me to stay. Few times, I've subtly tried to leave, invariably a staffer was there to ask, 'Where are you going?' "

(And just where did I think I was going anyway, I ask myself now.)

"Three meals today!" That was a first for me: I hadn't had that many in a day since I'd been a boy; what a victory. And now, I know that when I wrote those words that I was starting to come back from the dead.

"Being afraid to call for help initially; the old 'I don't want to bother anybody' syndrome . . . . Early days before it all happened; despair; maybe hope now. . . ."

It ends there, on that note, and as I sat in the kitchen at the table and looked at the boxes of stuff around me, I thought of all that has gone on since those days in the hospital.

And this time, it was easy to pray, and rather than a prayer with a plea for my life to be spared, it was a prayer with a passion to express a gratitude that continues to be unending.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Detox phobia plagues addicts

Fear of being detoxified from methadone maintenance can be so great in some patients that it is pathological, say researchers from three United States centres. Several tests, including a Detoxification Fear Survey Schedule which assesses the degree of emotional disturbance associated with detoxification, were used to evaluate 271 randomly selected patients from three methadone maintenance programs in Sepulveda, California; Philadelphia, Pennsylvania; and Birmingham, Alabama. The researchers found the incidence of detoxification fear ranged from 22% to 32%. They note it is unlikely the fear is due to pressure or coercion to detoxify by staff, because none of the three clinics studied had policies requiring detoxification. The researchers say the findings show there is a sub-group of opioid addicts with an intense fear of detoxification and avoidance behavior severe enough to be classified as a phobia. Those with detoxification fear tended to have longer histories of addiction, were older, and a greater proportion of them were women. Detoxification fear may explain why some patients who meet reasonable rehabilitation criteria refuse gradual detoxification. Because irrational fears and phobias are relatively easy to treat, the researchers conclude interventions should be developed to treat this disorder.

American Journal of Psychiatry, June, 1986, v.143:739-743.

A men-only alcohol effect

Alcohol has an impact on the breathing patterns and oxygenation of men during sleep, but not of women. Details of this differential effect, as yet unexplained, were reported by researchers from Gainesville, Florida. They monitored the breathing and oxygenation of 78 asymptomatic volunteers of both sexes and various ages on two successive nights of sleep. Following ingestion of either placebo or two milligrams per kilogram of alcohol, patients slept and a variety of measurements such as polysomnography and electroencephalography were taken. Alcohol ingestion shortened sleep in men older than 40 years and post-menopausal women. However, no effect of the alcohol on the breathing or oxygenation was seen in any group of sleeping women. In the men, alcohol ingestion increased the numbers of desaturation episodes and caused more severe oxygen desaturation during sleep. The researchers say the physiologic reason for the difference between the effects of alcohol ingestion in men and in women is unknown, although they speculate hormonal differences may be responsible. They say their study confirms the sex difference previously shown only in animals. And, because alcohol is known to promote obstructive sleep apnea, studies of protective mechanisms should be limited to men.

The American Journal of Medicine, April, 1986, v.80:595-600.

Withdrawal from nicotine gum

Nicotine gum may have unforeseen pitfalls for the ex-smoker. A study by three researchers from the psychiatry department of the University of Minnesota, Minneapolis, has shown ex-smokers may become physically dependent on nicotine gum, leading them to use the substance beyond the recommended period of three months. Eight ex-smokers each using about 10 pieces of nicotine gum daily were given either nicotine gum or a placebo in a double-blind, randomized, cross-over trial. The majority had been using the gum for longer than three months. When the placebo gum was substituted for nicotine gum, symptoms similar to those seen with tobacco withdrawal were noted in seven of the eight subjects. In two cases, the subjects relapsed while receiving the placebo, one to smoking and the other to nicotine gum. The relapses were preceded by the two highest ratings of observed withdrawal. The frequency of physical dependence in this study is greater than that reported for behavioral dependence on nicotine gum, so the researchers suggest only a subset of those physically dependent on the gum will go on to develop behavioral dependence. The researchers conclude physicians should continue to emphasize to patients the need gradually to reduce their intake of nicotine gum to avoid withdrawal symptoms and dependence.

The Journal of the American Medical Association, June 20, 1986, v.255:3277-3279.

Honolulu data link stroke risk, alcohol

Another report from a long-running study of a group of Hawaiian men provides further evidence of the relationship between alcohol use and stroke. The report indicates alcohol has a greater effect on hemorrhagic stroke. The data, from researchers affiliated with the Honolulu Heart Program, have followed about 8,000 men since 1965 in a prospective study of cardiovascular disease. In 12 years, 197 subjects classified as consumers of alcohol have had a stroke, compared with 93 non-drinkers. No significant relationship was seen between alcohol consumption and thromboembolic stroke. But, the risk of hemorrhagic stroke more than doubled for light drinkers and nearly tripled for those considered to be heavy drinkers, compared with non-drinkers. The relationship persisted when investigators controlled for hypertension and other risk factors. The researchers speculate alcohol might precipitate an acute rise in blood pressure which could lead to hemorrhage. Or, alcohol may impair the coagulation process that could increase the trauma of a cerebral hemorrhage. They say their findings also suggest subjects who reduce alcohol intake can also reduce their risk of stroke, and drinkers should be advised of this.

The Journal of the American Medical Association, May 2, 1986, v.255:2311-2314.

Pat Rich

Need to relieve social stress leads teens to alcohol . . .

By Elda Hauschildt

SASKATOON — Alcohol is the major drug used and abused by teenagers today because they use it to relieve stress, says the chairman of the Saskatchewan Alcohol and Drug Abuse Commission (SADAC).

And, adults should direct prevention efforts with young people to providing "some sort of safe passage through the teen years." Saul Cohen, MD, told the 2nd national conference of PRIDE (Parent Resources Institute for Drug Education) Canada here.

"Young people seek alcohol in the passage from teen to adulthood as a teenage stress reliever. They use it as a tranquillizer and a drug. . . . The ones we talk to say it makes them less shy, less nervous; it makes them feel a part of the group."

The safe passage that prevention efforts could provide, Dr Cohen said, would be based on young people "making a responsible decision in the light of the law, in the light of the teenager's maturity, and on reliable scientific knowledge, as opposed to knowledge obtained from the street."

Recent national surveys by Health and Welfare Canada (**The Journal**, April) and Ontario surveys by the Addiction Research Foundation, Toronto (The Journal, December, 1985), "confirm many of our day-to-day observations," he added.

"By grade 12, 90% of students have tried alcohol beverages; 30% get drunk at least once a week. Even by grade 7, half of the students report familiarity with alcohol.

"Alcohol use has become very much a part of the social curriculum."

Dr Cohen said teen alcohol use is a problem "that has escalated since the drug phenomenon of the 1960s and 1970s." In the late 1950s and the 1960s, teens made up only 1% of SADAC's caseload; today, teens represent 6% of SADAC patients.

He also related the increase in teen alcohol use to societal changes.

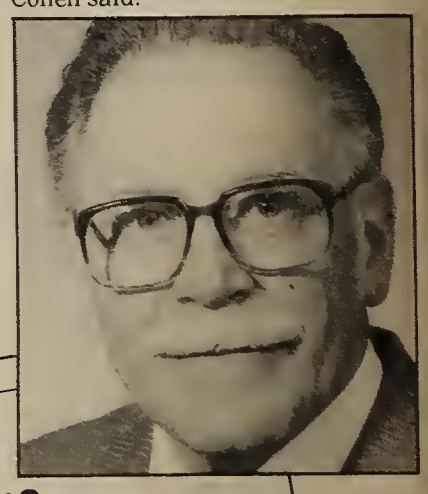
"It's the age-old supply and demand formula. We know that increased accessibility and availability lead to increased consumption, which in turn leads to an increase in the number of problems."

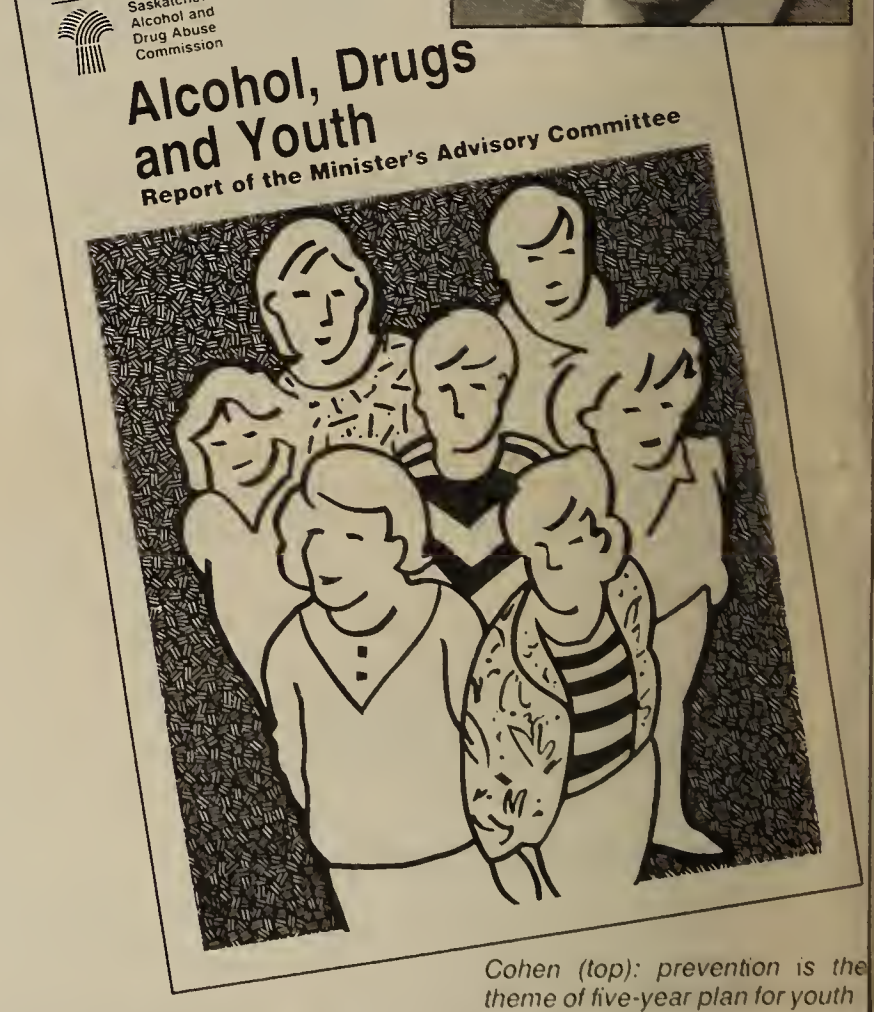
Lowered drinking ages and increased disposable incomes exacerbate the problem.

"As well, in society, we have adopted a more liberal — some would say, cosmopolitan — attitude toward alcohol consumption. It has become a part of adult society as well as teen society. The use of alcohol is widespread and associated with the image of smart living, athletic heroes, and television characters, on (shows like) *Dallas* and *Falconcrest*.

"The legal age for drinking is seen as a rite of passage to adulthood. Drinking with friends is seen as a vehicle for communication, for membership in a group, and for adult-style behavior. All these things have contributed to the wide acceptance of alcohol by many of us in society."

It is important, also, to see teenage alcohol and other drug use "on a continuum, from the experimenters, to curiosity seekers, to those who become truly addicted," Dr Cohen said.





Cohen (top): prevention is the theme of five-year plan for youth

. . . Saskatchewan tries to help

SASKATOON — Saskatchewan will have ready this fall a five-year plan to deal with increasing alcohol and drug problems among the province's 113,800 young people.

The five-year plan, to develop and coordinate prevention, intervention, and treatment services for adolescents aged 12 to 18 years, is one major recommendation among 50 made by a government advisory committee last May, after an eight-month study of the problem.

The Saskatchewan Alcohol and Drug Abuse Commission (SADAC) is coordinating development of the plan, in conjunction with provincial health, social services, education, and justice departments.

SADAC Chairman Saul Cohen, MD, told a PRIDE (Parent Resources Institute for Drug Education) Canada conference here, SADAC has seen the teenage segment of its caseload grow to 6% (of 9,000 clients in 1984/85), from 1% in the late 1960s. Of the 500 teenagers seen in 1984/85, 200 were inpatients.

He reviewed several other indicators of youth alcohol and other drug problems in the province:

- in 1984, nearly 1,400 teens were convicted of impaired driving;
- in 1984, Saskatchewan's teenage suicide rate was 18 per 100,000, compared to a national average of 12.7 per 100,000. This includes a high rate among Native young people, "six times the national average for all other Canadians;"
- in 1984, 27 young people died in automobile accidents, with alcohol involved in 50%;
- "social workers and police officers are quick to point out that alcohol plays a very large role in juvenile delinquency and teenage crimes."

Parents, young people, police, teachers, and Native groups were involved in the provincial advisory committee set up by Health Minister Graham Taylor. The committee travelled throughout Saskatchewan for public hearings and received 144 submissions from individuals and groups. As well, committee members visited schools (grades 7 to 12) during regional visits and heard first-hand from approximately 300 young people.

The committee heard resource panelists discuss the nature of adolescent addictions, treatment approaches, prevention strategies, and the role of the school.

Other major committee recommendations include:

- review of existing assessment and referral procedures for youth so guidelines can be developed;
- evaluation and recommendations on an inpatient adolescent treatment facility, with related outpatient programs;
- establishment of healthy lifestyles education as a compulsory core subject for all grades;
- development of guidelines for the training of qualified school counsellors;
- encouragement of standard guidelines referring to the use of illegal drugs and alcohol by people less than 19 years of age (the provincial standard) for youth-related sport, recreation, and culture associations provincially funded;
- implementation of an extensive, on-going media campaign promoting healthy lifestyles to complement community-based activities; and,
- provision of funds for a division of youth services within SADAC to coordinate youth services and programs.

NEWS AND COMMENT

Heart scarring shows in cocaine sudden deaths

By Jean McCann

PORTLAND, Oregon — A researcher predicts an epidemic of sudden deaths in cocaine addicts from heart problems rather than overdoses.

Steven Karch, MD, says cocaine use causes enough patchy scarring of the heart to disrupt the organ's electrical system and cause the drug user to die of a cardiac arrhythmia.

It's not known how much cocaine is needed to produce this lethal scarring.

"There are a lot of people out there who have to be worried," Dr Karch told **The Journal** following his report to the annual meeting here of the University Association for Emergency Medicine.

In 1984, in San Francisco, there were approximately 34 sudden deaths in cocaine users; that number is expected to double in 1986.

Examination of the hearts of those who died showed contraction band necrosis, strips of scarred muscle occurring randomly throughout the organ, Dr Karch said.

"The San Francisco coroner is one of only two (in the United States) who looks at microscopic sections of the heart. We were able to go back and pull all the autopsy tissues from these patients and review them."

Dr Karch, of the University of Nevada, Las Vegas, said heart damage to cocaine users (**The Journal**, February) is quite different from what occurs with a heart attack. Scarring among cocaine users is almost random throughout the heart, rather than in certain areas.

The damage likely results from the rising levels of the catecholamine norepinephrine which occur when cocaine is used.

"When these people died, their hearts showed extensive destruction from catecholamines. We think what killed them was the combined action of the catecholamines with the fibrous areas, which, when healed, do not conduct well."

He said low potassium levels due to stress may also contribute to these sudden cardiac deaths.

"This was an interesting group of people. They were predominantly white, more than 80%, and predominantly male, more than 90%. They had a median age of only 33.9 years."

The deaths are different from those of cocaine overdose patients, who usually develop seizures.

Dr Karch said the cocaine sudden death patients were also compared with patients dying of sedative-hypnotic overdose, who might also have heart scarring caused by lack of oxygen during resuscitation efforts.

Dr Karch: "The differences between the two groups were very striking. But, what is more frightening is that the number of cocaine sudden deaths in 1984 looks to be about half of what we are going to see in 1986."

Although one or two episodes of cocaine use may not be harmful, Dr Karch said, "over the course of time, sufficient scarring of the heart and sufficient alteration of metabolism occurs."

The hearts in cocaine sudden deaths also looked like those of people who "died of fright."

Dr Karch: "We have looked at the hearts of Vietnamese boat people who died of nightmares, and they have contraction band necrosis. In general, of all people dying of sudden death, not just cocaine patients, 80% can be shown to have this particular kind of scarring."

In cases of sudden death, only 15% were found to have clotting of their coronary arteries.

Dr Karch said this is the first study showing the relationship, by autopsy findings, between cocaine use and sudden cardiac death.

There was evidence of alcohol use as well in 70% of the cocaine sudden death group. And, 60% were found to be intravenous drug abusers, so not all were smoking cocaine or snorting it.

Second award in one year

RCMP Estimates honored

OTTAWA — The Drug Enforcement Directorate of the Royal Canadian Mounted Police again received an award of excellence for the publication, *The National Drug Intelligence Estimate 1984/85*.

Robert Fahlman, chief, strategic analysis and publications section, reports the publication received the 1986 award in the English writing and editing category at the 8th Annual Information Services Institute Conference here.

The publication has been recognized for excellence by law enforcement intelligence analysts in two consecutive years.

Shelley A. Keele and Hélène Vigeant accepted the award.

GILBERT

Is beer better for you?

A recent article by Alex Richman of Dalhousie University and his associate, Reg Warren, questions the common view of alcohol researchers that there is little or no difference among alcoholic beverages in their ability to cause ill-health. The usual argument, one that I have espoused, is that only the amount of alcohol consumed counts, no matter how it is taken.

Between March, 1980, and January, 1984, I devoted five columns to the implications of a possible beneficial effect of alcohol consumption on heart disease. If moderate use is better for health than excessive use or abstention, I argued, we should be working out what might be optimal daily consumption and trying to get as many people as possible to drink that amount.

Changed thinking

As I noted in my December, 1984, column, my thinking on this matter changed when I became aware of analyses by Dr Richman and Mr Warren of data from the Canada Health Survey, in which the health of a probability sample of 17,249 Canadians aged 16 years and older was determined using questionnaire and clinical methods. They had presented their findings at the May, 1984 meeting of the American Association for the Advancement of Science. Dr Richman had also sent me a longer paper for review.

In that work, they confirmed previous findings that moderate alcohol use is associated with better health than abstention or excessive use. However, they pointed out just about all of the difference in health between abstainers and moderate drinkers could be accounted for in terms of age, sex, income, and other characteristics. It seemed that moderate use might occur as a consequence of good health, rather than vice versa.

Their research was published in June last year in the journal, *Drug and Alcohol Dependence*, with a further analysis that confined the association between moderate alcohol use and good health to beer consumption.

Research vs policy

The paper begins with the important observation that the research and public policy sectors reflect different assumptions about the relation between alcoholic beverage type and health outcome.

Public policy frequently gives preferential treatment to beverages with lower alcohol content, particularly to beer. In Ontario, for example, taxes increase disproportionately with alcohol concentration from beer to wine to liquor. The sale of beer and wine in corner grocery stores is being discussed, but not the sale of liquor. Only beer may be sold at baseball games. Liquor is not advertised on television. In some jurisdictions, young people may consume only low-strength alcoholic beverages.

Researchers, on the other hand, are fairly united in their view that differences between beverages are not significant — that only total alcohol consumption matters. There is actually little evidence on the matter. Dr Richman and Mr Warren took Addiction Research Foundation, Toronto, researchers to task for using the absence of data to argue that inter-beverage differences may not be important.

The authors could have used as an example another 1985 study of morbidity and alcohol consumption involving data from the Canada Health Survey. Dr Randall Coates and colleagues from the University of Toronto reported in the journal,

Medical advice is usually consistent with the researchers rather than the policy makers

Preventive Medicine (January, 1985), they could find no relationship of any kind between alcohol use and blood pressure. Like most other researchers, these authors did not examine inter-beverage differences. They assumed drinks of equal alcohol content had equal potential for harm and, as a consequence, aggregated them.

Medical advice is usually consistent with the researchers rather than the policy makers. For example, Dr Robert Linn, in his 1979 book, *You Can Drink and Stay Healthy: A Guide for the Social Drinker*, asked the question, "Are some alcoholic beverages 'better' for you than others?" They are, he replied, only to the extent they have value as a nutrient, and "there's a big difference between drinking and staying healthy, and drinking in order to be healthy."

New analysis

Dr Richman and Mr Warren's new analysis examined morbidity in relation to alcohol consumption for each of six categories of reported beverage preference.

Morbidity was constructed as a dichotomous measure. Morbid respondents (22% of the total) were those who had reported one of the following incidents during the previous two weeks: days in bed as a patient; days away from work, school, or housework; days in which activity was reduced on account of illness; and, visits to a physician on account of illness.

Respondents to the Canada Health Survey had been asked about their alcohol consumption in two ways: frequency during past year, and quantity during previous week. They were also asked to indicate their usual beverage preference. The 17,249 respondents were thus categorized in six groups, as follows:

Beer drinkers	**3,056**
Wine drinkers	**1,046**
Liquor drinkers	**2,235**
Mixed preference	**2,233**
Not current drinkers	**5,171**
Drinking habits unknown	**3,508**

The expected morbidity was estimated for each of the six groups, taking into account differences in age, sex, income, and other factors. (Beer drinkers tended to be young, male, and from lower-income groups, whereas wine drinkers tended to be older, female, and from higher-income groups.) The actual morbidity for each group was compared with its expected morbidity. Beer drinkers had significantly lower actual morbidity. None of the other groups had morbidity that was significantly different from what was expected.

When the analysis was further refined to take into account consumption within these groups, some consumption categories showed significant differences between actual and expected morbidity for both beer drinkers and liquor drinkers, all in the direction of reduced actual morbidity. However, for the estimation of quantity of alcohol consumed, only some of the categories of beer drinkers indicated significant differences between actual and expected morbidity.

Specifically, beer drinkers who reported consuming four to seven drinks in the previous week had 27.8% lower morbidity than expected, and beer drinkers who reported consuming 15 to 34 drinks in the past week had 23.5% lower morbidity. Most of the other consumption categories for beer drinkers showed reduced morbidity, but none was significantly reduced, including the category of those reporting a consumption of eight to 14 drinks in the previous week.

Conclusions

Dr Richman and Mr Warren made the following statements about their results:

- "Taken together, these results imply strongly that drinking beer regularly and in moderate quantity may be associated positively with health status.
- "While it is true that within this population increases in the frequency of beer drinking are associated with apparent improvements in health, it cannot be stated that this health improvement is necessarily attributable to beer drinking frequency.
- "There is no evidence, that the somewhat poorer health of excessive drinkers occurs with a frequency sufficient to offset the apparently better health of the majority of moderate beer drinkers.
- ". . . Comparative studies based upon indicators such as 'absolute quantity of alcohol consumed per capita' may provide misleading results if the contribution of specific beverage-types to per capita consumption is not taken into account."

Explanations

Five possible explanations were offered for the results:

- Beer may be better than other alcoholic beverages because its alcohol is more diluted and because it contains more minerals and vitamins.
- Beer is consumed disproportionately in taverns, pubs, and other public settings that may provide a healthier environment than private settings, on account of the social and psychological benefits they provide to their patrons.
- Healthy individuals may tend to indicate beer as their beverage of choice, no matter what their actual preference — possibly "mute testament to the success of mass advertising."
- Beer advertising may contribute "to the adoption and maintenance of positive lifestyle behaviors, by encouraging individuals who consider themselves beer drinkers to emulate the healthy lifestyles shown in the advertisement."
- Beer drinkers may under-report the true extent of illness in relation to consumers of other beverages because "labelling oneself a beer drinker and labelling oneself as ill may be mutually contradictory to some degree."

Dr Richman and Mr Warren's plausible research was sponsored by the Brewers' Association of Canada and the United States Brewers' Association.

By Richard Gilbert

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Marijuana's link to AIDS: 'chop-logic' . . .

I was most disturbed to find the newest twist on AIDS (acquired immune deficiency syndrome) hysteria on the front page of the May issue of **The Journal.**

The evidence cited by Ian Macdonald (MD, administrator of the United States Alcohol, Drug Abuse and Mental Health Administration [ADAMHA]) for an AIDS/early marijuana use link is such a classic example of chop-logic that I shall use it in future semesters as a negative example for my epidemiology students.

Given that intravenous (IV) drug use is a major route of infection for AIDS and that most IV drug users also smoke marijuana, it is certainly not surprising to learn that many AIDS victims have used marijuana.

Likewise, since butyl nitrite is used by a large proportion of male homosexuals, it is not surprising to find its use to be common among AIDS victims. Since most people in the United States drink alcohol, it would be truly a major finding if a majority of AIDS victims didn't.

These sorts of crude associations are known to any statistician as confounding of variables.

Is there any AIDS/marijuana link? I don't know. But, nothing in the report in your May issue constitutes evidence that there is or even that there might be.

You can hardly ignore such a shocking pronouncement from a major figure like Dr Macdonald, but surely you could have called on some competent authorities on AIDS epidemiology to put his remarks in context.

Dr Macdonald asked why there hasn't been "national panic about drugs" in relation to AIDS. Perhaps, the answer is that the public has learned to panic less easily than ADAMHA and Dr Macdonald.

David F. Duncan
Professor of Health Education
Southern Illinois University
Carbondale, Illinois

. . . 'absurd,' readers say

The May issue contained a front page story linking marijuana with AIDS.

The article quoted Ian Macdonald, MD, the administrator of the ADAMHA, as saying 26% of AIDS patients are intravenous drug users who started with marijuana. The implication is that, therefore, marijuana use causes AIDS. This rationale takes the disproven "stepping-stone" hypothesis to its absurd extreme. It is amazing such conjecture is quoted as front-page news without any alternative views to balance it.

The article also fails to report on recent research on marijuana and the immune system. Herman Friedman, PhD, of the University of South Florida, Tampa, recently announced the results of a two-year study he conducted for NIDA (US National Institute on Drug Abuse).

He found large doses of THC (delta-nine-tetrahydrocannabinol) injected into rats (much larger [doses] than anyone could smoke) adversely affected the immune system, but lower doses enhanced the immune system (**The Journal**, July).

He concludes lifestyle, ie, diet, sleeping habits, exercise, have a greater impact on the immune system than marijuana. These findings are consistent with many other studies on marijuana and the immune system.

Dr Macdonald and other spokesmen for the (US President Ronald) Reagan Administration would love to be able to say marijuana causes AIDS. Indeed, they are already saying it, even though the evidence may actually show moderate marijuana use prevents AIDS.

Kevin Zeese
National Director
National Organization for the Reform of Marijuana Laws (NORML)
Washington, DC

'Mine was yellowed'

Clean copies please

I enjoy **The Journal** very much. It is informative and well put-together.

However, apparently someone read my latest copy before mailing it. There was yellow underlining throughout the centre section on the Conference of Ministers of Health (June, May).

I would like to use this section for a class I will be teaching this fall. Could you please send me two clean copies, with the bibliography?

I would also appreciate it if you would pass on to Richard Gilbert that I think he is the best columnist I have ever read.

Judith Lacerte
Assistant Professor
Eastern Washington University
Cheney, Washington

(Ed note: The yellow highlights are a deliberate design device to emphasize key points in the articles. But, you're not alone. We've had several comments about 'secondhand' copies.)

Fan club for Inside Out

Please enroll me in the fan club of the author of The Journal's regular column, *Inside Out*.

It's the most poignant and insightful column I've ever read, and I sincerely hope the author writes a book.

Joanne Rice
Probation/parole officer
Correctional Services
Windsor, Ontario

Adult CoA applauds info

I am an adult child of an alcoholic (CoA). Your articles (May, April, 1985; October, 1984) were very informative and helped me to understand myself better. Keep up the good work and the research.

Could you please send me the mailing address for the United States National Association for Children of Alcoholics?

Thank you.

Christine Martincheck
Houston, Texas

The Kabay Diary

The Story of a Pioneer Scientist Couple in the Years of Hungary's Deepest Depression 1924-1936

Ilona and Janos Kabay

Adult memories of childhood years, perhaps fragmented by time and distance, often blur the reality of that earlier life.

Today in Australia, however, a brother and sister, now in their senior years, have vivid, special insight into their early lives.

They are John Kabay and Ilona Kabay Oltvanyi. And, their mother, Dr Ilona Kabay, wrote a journal about life with their father, her husband, Janos Kabay. This personal diary for her children was her insurance that their short years with Janos Kabay would not be lost to time.

What makes Dr Ilona Kabay's diary of interest to the international scientific community is the professional achievement she records, for Janos Kabay was the scientist who invented the process for extracting morphine from poppy straw. And, even in today's highly sophisticated laboratories, his work is still the basis of the process used by many manufacturers who supply the drug internationally for medical use.

Janos Kabay died tragically at the age of 39 years in a Hungarian hospital, with his wife, his research partner, by his side. Her diary for her children is an accounting of their short years together; times of sacrifice, despair, and, ultimately, a triumph of sorts.

Dr Kabay and her children emigrated to Australia in 1950 after having spent a few years in Austria.

John Kabay, wanting to make the story of his parents better known, translated his mother's diary into English and sent it to Peter White, a senior writer at the National Geographic.

In his correspondence to Mr White, John Kabay reflects on some memories of his youth in Hungary: "My early childhood was spent amongst poppy fields and in laboratories where morphine was crystallized. . . . Janos Kabay's work is part of the development in the modern manufacture of opium alkaloids."

Mr White's enthusiasm for the diary, and belief in the scientific integrity of Janos Kabay, led to his correspondence with Frank Potts, chairman of the Poppy Advisory Control Board in Tasmania, where Mr Kabay's invention is still being applied in modern factories.

Mr Potts wanted to bring the Kabay name out of relative obscurity and see recognition given for his pioneering research.

Thus, on January 29, 1986, the 50th anniversary of Janos Kabay's death, and some 25,000 kilometres away from his native homeland, a plaque in his honor was unveiled at Stoney Rise, Devonport, Tasmania. Among representatives of the Australian and Hungarian governments, the International Narcotics Control Board, and every segment of the Tasmanian Opiate Alkaloid Industry, stood Ilona Kabay Oltvanyi and John Kabay.

From Tasmanian government official Roger Groom, they heard public recognition, for the first time, of their father's achievements: "Science and technology have advanced a long way since Janos Kabay started his work in 1925 on extracting alkaloids directly from the poppy plant, and the establishment, in 1927 of the first small factory in Hungary.

"There can be no greater tribute to a scientist than for his work to continue to be built on. And, this is what has been happening in Tasmania."

Mr Potts sent the diary to The Journal. *He said: "We in Tasmania are privileged to recognize not only the dynamism of the man, but also the part played in his work by his wife and those who worked with him during this time, both in the laboratory and the alkaloid factory, and who stood by him with trust and loyalty."*

In this special section, The Journal *presents a condensed form of the diary, with a forward written by the Kahays' daughter, Ilona, and a postscript by their son, John.*

Foreword

By Ilona Kabay Oltvanyi

Very few among us have the gift to create, especially to create something new that lightens the burden and changes the lives of people coming after them.

Janos Kabay, a young Hungarian pharmacist, the inventor of a new method of producing morphine, is one of those men whose name and achievement far outlived his short life. . . .

Iluczi (as he lovingly called his wife, Dr Ilona Kelp) stood by him always with unselfish devotion. She, a doctor in chemistry, understood fully her husband's theories and, with her precise reports, kept an indispensable record of the workings of his brilliant mind.

They had had only 11 short years together when Janos died. For Iluczi to remain by herself was cruelly hard. She wrote the history of their life together and of the birth of the *Alkaloida* factory to ensure her children, Janos and I, would always remember.

Iluczi died in Sydney, Australia in 1970 and was buried with her husband in Budapest.

Sydney, 1972.

The Kaloy

29th March, 1936

My children, darling little Janoska and Icike!

It is two months since your father finally closed his sparkling, soulful eyes, and after six hours of death-defying, silent battle, left us.

My little ones, you have no mother; you don't know it yet; my heart died on that terrible night as I sat on the rough hospital bed beside your father.

But, I am here. Life gives strength to the healing, and that is how it has to be. You must be well and happy — but you must never forget.

I know he will always live in your hearts with his radiant smile and his cheerful voice. You will always know how rich and happy you were in the first short period of your lives, because somebody carried you on his palm and protected you from harm. His arm dropped away before it could give you everything he wanted to give you . . . . He wanted to give you so much . . . .

That is what I want to write for you: who your father was.

What I want to give you now is only a sketch of your father's life, our life, an account of his struggles, a description of his superhuman achievements. I know my pen is too weak for the task, but read it with as much love as I write it for you.

I am reading old letters, sorting through old notes and press old photos to my heart. The dawn is breaking before I start.

My Janos! Pictures of your life pass through my mind. From the time when as a little boy you wanted to catch the rainbow, right up to the time we met. From then on, our lives were welded together, struggling and fighting together, crying and laughing, at times in the deepest troughs and at times on the highest peaks.

Oh what a life this was — the sum total of everything that life can give; complete harmony to the last nuance; faith without bargaining; limitless devotion.

How many disappointments, how many battles, how much exhausting labor, and yet, not a word of complaint — just one wish, "We should never be parted."

We had three darling children, raised with trembling care. The factory was the third, the smallest, the weakest, brought up with the most trouble. How much fear and worry is in every sentence when we write about it to each other. When it is still small and weak, miserable, barely alive, and it cannot fly straight away, everybody turns their back on it with mocking contempt. But, we are certain if it is killed, so is our honor, and with honor our life also.

* * *

1st September, 1924

On a beautiful, sunny, autumn day, both of us started at the Botanical Experimental Institute, two new chemists: your father and I. September was always my favorite time. I felt it had to bring something new, beautiful, some beginning. On this September day, our real life started.

We came from dissimilar backgrounds, met after different studies. Our aims and work expectations were different also.

Janos, after receiving his pharmacy diploma, came to Pest to work for his pharmacy doctorate at the Pázmány Peter Science University. He was a country boy, in his 28th year, slim, middle height, with brown hair. He was serious, with good features, and his intelligent brown eyes spoke of enthusiasm and ambition.

At first, he wanted to be a mechanical engineer. But in 1915, he was called up for the army, and his studies were disrupted. By the end of the war, his two older brothers had finished university, Peter as a pharmacist and Josef as a medico. Janos decided to become a pharmacist.

At that time, pharmacy studies started with two years of apprenticeship in a pharmacy, which he spent in his brother Peter's shop. That finished in 1921. He came to Budapest to the university, financed partly from his savings and partly by Peter. (He paid it back, keeping exact accounts.)

After he successfully completed university and one more year's practice, he sat for the final exam and accomplished excellent results. By this time, he wanted to be a research chemist and spent endless hours experimenting in the little laboratorium behind the pharmacy, where the first poppy trials also occurred.

He was offered a position at the Botanical Station with the quiet agreement that in his own time he could work on his dissertation for the doctorate. His assignment was the analysis of narcotic herbs.

I was in my 27th year, 10 months after getting my doctorate in chemistry and physics. (I obtained it *summa cum laude* at the Pázmány Peter Science University after five years.)

I was already working at the experimental station of the Ministry of Agriculture. I was a city girl, half orphan, and from my 15th year worked not only for my tuition but fully sustained myself. I got job offers from the Botanical Biological Institute, the Fermentation Study Station, and the Botanical Experimental Institute. I chose the last one. State assistant-chemist was my title, and analysis of fragrant oils was my assignment.

That is how we were swept together on that autumn day, two lonely souls, by destiny. From the first minute, interest and sympathy drew us toward each other. We were put together in a corner laboratorium. The first sympathy quickly deepened, and we related our countless lonely dreams. In January, he asked for my hand, and on the 18th, we got engaged.

At this time, Janos already had a burning wish to produce something which would secure a solid base for our marriage. The idea had already surfaced: how could one extract morphine from the poppy plant (*Papaver somniferum*) which abounded on the Hungarian plains. Only imported morphine was available in our homeland, so during the war it was often sadly missed.

The accepted idea of the time was that morphine does not exist in the poppy plant and that the basic molecules can be found only in the sap of the plant. Traditionally, opium was obtained in the Far East by cutting into the unripe capsule of the poppy. A milk-like juice seeped out which solidified in brown droplets and was collected by countless day laborers. Morphine was gained from this crude opium.

Naturally, strict control was impossible, and many lives were ruined by opium alkaloids which passed through unscrupulous hands. Producing morphine directly from the poppy plant could bypass many difficulties in this uncontrollable and laborious process.

Janos started his experiments with the few plants which grew nearby. He soaked the poppy capsules and thickened the extract on trays in the sun. He then carefully bottled this concentrate and brought it to the Institute.

When we analyzed the extract, the results were negative; we barely got a reaction for morphine. This was not surprising since there was not enough raw material and there were too many process stages. We were granted the use of a quarter acre at the Botanical Experimental Station where we could sow more seeds.

Meanwhile, we worked on other assignments — the analysis of *Iris germanica*, the extraction of lavender oil, the testing of the althea root, etc. Janos had two dissertations published.

We also decided that we would not wait any longer. On the 30th May, 1925, Pentecost Saturday, we got married in the church at Varosmajor. We had no money for a photographer and so have no memento of this happy day.

Back in Budapest, we budgeted our little salary, collected our non-existent culinary arts, and started our married life.

By July, I realized I was expecting and we spent the rest of the year in the laboratorium and in waiting. By now, Janos had already abandoned his plans for university and a doctorate, and in his free time concentrated on studying all the available literature on alkaloids.

16th March, 1926

Our first child, Janoska, was born; a beautiful, sweet, healthy son.

In the spring of 1926, the serious work started. We needed some machinery, a small motor, chopper, shaker, larger extractor, glassware, vacuum filters. These expenses were financed by Peter.

In May, I was back in the lab, and we worked together on everything. In June, we started the harvest. Janos carefully sieved and concentrated the hydrochloric extract.

What exultation when, with ammonia, we separated the first morphine. Naturally, the quarter acre was not enough for qualitative production, but the process was healthy.

Now came the registration of the patent.

Heather Graham

Janos wanted it in both our names, but I did not allow it. I was his assistant, helped him, and wrote the notes. The invention, from the first idea to its execution, without any precedent, the brilliance of its solution, was exclusively and wholly his work. That is the one thing nobody ever can take away from him. When the invention was documented (that is the "Green Process," using green poppy plants), we went to Budszentmihaly for summer holidays. Janos felt he must start the commercial production of morphine in the village where he was born.

This was the start of the factory's foundation. The company was registered as the "Alkaloida Pharmaceutical Factory." For us, the invention was accounted for with foundation shares, half of which Peter got for his initial financial assistance. Other family members and local friends contributed to a lesser extent.

We bought the grounds for the factory opposite the railway station. The plans for the machinery and equipment were all done by Janos. In the middle of these feverish and nerve-wrecking months, in August, I realized I was pregnant again.

I did not like the quick tempo. I felt we should wait a bit longer since more exact tests were needed. An industrial process can be very different from a test tube experiment. I was not doubting the correctness of the invention, but I did worry for all the others, the little people who put up their savings and whose future depended on us.

But, I could not utter a word. The entire family blindly trusted and could not hurry the preparations enough. So, I accepted it.

In October, I gave up my job. For health reasons, I got a small pension, which later was sometimes our entire income.

Early in 1927, we moved to Budszentmihaly. Since the building, which also incorporated our home, was not finished yet, we rented a small farmer's house nearby; mud floor in the kitchen and fuel stove. Here, you really had to be a housewife.

Zsuzsanna, our household helper, arrived and stayed with us for many years. Being a city girl, I did not know where to start cooking, baking, and tending animals. Janoska was crawling, but he stayed in his playpen, out of harm's way.

Janos spent all his time at the factory, and at night, we both just dropped into bed.

Easter, 1927

Finally, we moved into our home at the factory. We had everything: two rooms, a hall (which we promoted to nursery), a kitchen with a huge baking oven in the middle, and a bathroom. We also bought a couple of nice curtains, a small rug, and a bedspread.

In the factory, the first extractors were being installed, and the carpenters were hammering together the workbenches. On the 5th of May, our little daughter, Icike, was born. We called Janos only when all was finished.

Zsuzsanna's hands were full with the household as well as with the chickens, the pig, and the vegetable garden. Icike was still a little angel, sleeping in her pram on the terrace. The humming of the machines was her lullaby, and she woke only when the noise stopped.

Meanwhile, they completed the boilerhouse, the cooling tower, the workshop, the chopper, the mixers, and condensers. Finally, the lab was ready for the separation and crystallization.

For the poppy, we rented a farm on the outskirts of Hajdunanas. Janos' parents moved out to the farm. The poppy grew nicely, it recovered after a severe May frost, and, in June, the district was flowering. How beautiful is a blooming poppy field, with its pale lilac flowers bending, undulating as far as one can see. In the original Green Process, the harvest has to follow immediately after flowering, when the petals have fallen and the milk is fresh in the capsules. The plants were taken immediately to the factory.

It was an enthusiastic, gifted bunch, with burning willingness to work and admiration and love for Janos, who worked with us. How proud was everybody who could work in the "Poison-factory," as the villagers called us.

July, 1927

The heatwave brought the first difficulties. The chopping and extraction went according to plan, but the filtration was excruciatingly slow, and the condensers could not take the tempo. The extracts were in drums in the blazing sun and started to ferment, foaming over the rims. Much of the precious material was lost even with the plant working day and night. Janos was present everywhere, and I did the assays.

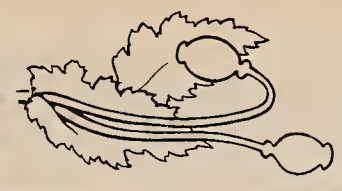
We could not salvage much: just enough to demonstrate the correctness of the process. The position was depressing and worrying. But, everything could be solved if just time was available.

In November, Janoska went down with a serious pneumonia. We were terrified for his life. He slowly recovered, but an alarming cough remained from it for years. I was not well either, but would not mention it to anybody; there was enough worry anyway and no money for anything.

January, 1928

We contracted the poppy crop locally. Janos built a mobile extractor, which chopped up the plants in the fields and pressed out the liquids into closed drums which could be trucked to the factory. The fluids were condensed right away into a syrup which could be stored without fermenting.

ay Diary



We dried this mass in frames to a solid, semi-finished product, which could be further processed with organic solvents. Everything appeared rosy. But when the harvest came, the weather was so bad we could not reap and process all the crop. The finished morphine was marketable but very scanty (less than 10 kilograms). So, we had to enlarge the plant.

In 1929, the search for money started again. We asked for a loan from the Ministry of Agriculture. The loan was promised, pending official formalities. Since time was pressing, we started the approved renovations. Extractors, a larger boiler, new drying frames were all on order. We had official contracts with the growers and would have been ready for the production of 100 kg of morphine.

Then, catastrophe struck. In April, the government changed. The new minister was not interested in poppy. The last signature was missing; the agreement did not bind him. He turned his back on our plight.

It was too late to stop the orders, the poppy was in flower, and in the renovated little factory, everything was ready. There was no retreat; we had to go forward.

Naturally, not all our creditors were willing to wait for settlement. Auction followed auction. Janos' beloved new motorbike was sold back to the agent for one-tenth of its original price. A few of the growers cooperated, but the rest demanded payment. Our money was barely enough to pay the workers.

The process went without a hitch. The half-finished, dried product was in storage, but there everything stopped.

If we could get a small loan to finish the product, there would be enough to cover everything.

Autumn, 1929 was the abyss of our misery. We were certain our idea was fit for life. The raw material was perfect; our method was elegant. But still, we could not produce. The torture of Tantalus.

Winter, 1929-30

The factory was at standstill. We did not produce anything concrete. All we needed was 15,000 pengo to start production again — what a paltry sum, impossibly out of reach. A family's honor, life, happiness, future depended on it.

This search for funds was very humiliating. For any assistance, we promised our future. We would have been willing to sell our lives.

We had one more ray of hope, the German Boehringer firm. They were willing to finance a trial production in Germany. But, without any explanation, they abandoned the plan. We learned later that our representative was demanding such an excessive honorarium for himself that the German firm withdrew in disgust.

People were wondering why a gifted, young man did not forget the lost cause and find work somewhere else. Why did he suffer all this humiliation? The inspiration of Janos Kabay did not accept detours. There was no stopping him.

Christmas, 1929 and everything seemed hopeless and in vain. Tearfully, we had to dismiss our real friends, the workers, after sharing with them the last provisions left in the house. From our last credit, we decorated a tree and baked a cake.

We closed up the factory and our home and travelled to Budapest, to stay with Mama for the winter.

Janos renewed his battle to make the government honor their unfulfilled promise, and, finally, they agreed that a way had to be found to keep the company operating. But, officialdom moved very slowly.

Spring, 1930

We returned to the deadly still factory; even the misery was more sufferable at home.

The workers turned up, hoping, never complaining, but their worn clothes and hungry faces were enough accusation.

Your father could not rest. He went back to Budapest, without a cent in his pocket, walking every day from the far suburbs to the ministries in the city. He appeared for business appointments in leaking shoes and threadbare suit.

Finally, I could not stand it any longer and came to Budapest also. After innumerable hours waiting for audiences, we succeeded in securing the patronage of the defence ministry. The government gave 15,000 pengo toward the finishing of the previous year's product.

August, 1930

Trial manufacturing began. With minimum expenditure, we restarted the factory. We missed out on the 1930 crop, but we were happy to work again. We were day and night in the plant and did everything ourselves. There was no engineer now, no analyst, not even an assistant. The children, two little neglected creatures with only their guardian angel watching them, wandered around the factory yard.

But, the third one needed us most; our every minute belonged to it.

What followed was three months of strenuous work, always accounting for every cent and every milligram of morphine. All production was under state supervision.

The production was a complete success; the firm could live on. But, for that year, the work was finished and so was our income, and, at the end of October, the factory's gates closed, even if not as hopelessly as before. Ahead again was another winter in Budapest, still without money.

This time we were working in the laboratory of the Institute again, since we had to solve the codeine question. It was not enough to produce morphine; we had to be able to make codeine also. What an unending struggle.

For three months, Janos started the experiments daily anew, without proper equipment, raw material, or money. Our clothes in tatters, every morning we had to mend our shoes with needle and thread before putting them on. But, we were cheerful, happy, young; we were together.

In January, all this work bore fruit. We had our first codeine (dimethylmorphine). We solved the methylation with dimethylsulphate; but, it was only qualitative. Because the reaction was reversible, the process was not suitable for commercial use. But, only the theory was important.

In the meantime, Janos' family was turning away from us with suspicion and distrust. They were anxious to see some return for the money they had invested. Only the workers wrote to us, the old faithful men waiting for a better future.

May, 1931

Victory! Finally the government agreed to subscribe shares, including the old loans, and raise the capital. After the long absence, we were home again. Life returned to the factory; repairs, renovations, preparations everywhere.

Winter, 1932

The third child grew rapidly, too big for its clothes. The Green Process could not satisfy it anymore. During the short summer season, we could not collect enough raw material to keep the plant occupied for the whole year.

The danger of factory closure threatened again. Your father dared to try the impossible: extract morphine from the dry poppy straw. Scientific circles were smiling or scandalized by the idea. The accepted opinion was that the alkaloids disintegrate during the poppy's maturing. That in the dry, chopped-up capsules, or in the straw, morphine could be found was considered complete nonsense.

During the previous winter, Janos had experimented with dried poppy straw. He felt instinctively that we had to find out the alkaloid content of the "worthless" dried straw and capsules.

After a few trials, he verified that the alkaloid content barely changes with the maturing of the poppy plant. The "Dry Process" was not only possible but proved to be simpler and much more practical than the Green Process. It was quickly patented not only in Hungary, but abroad also.

The new process needed completely new fittings. In the factory, within a few days, the workers built four huge homemade concrete tanks, the first drenching extractors. Following the drawings prepared by Janos, they also created all of the machinery, spare parts, and equipment.

The factory, our third child, put on its new suit without fanfare. Still, there was no recognition whatsoever from the interested parties.

How it hurt your father. How he craved a little acknowledgement, respect.

The Green Process, even though brilliant in itself, could have given only a limited basis for production. Without the Dry Process, the plant could have had very restricted operation only, and further development would have been impossible.

Despite continuous day and night production, there was no night-time supervisor. Your father worked from 5 am until midnight. With his rheumatic legs climbing 100 times from cellar to attic, he directed everything himself. His neglected arthritis gradually worsened; there was no time or money for cure. I had to tape his legs up every morning so that he could move around in slippers, Often, at nighttime, I had to put him to bed like a little child, undressing and washing him. Still, the slightest change in the beat of the machines woke him with a start, and before anybody could notice the trouble, he was on the spot to take care.

Summer, 1932

There was no stopping. The building started again. We became the sole suppliers of morphine in Hungary. Our existence was guaranteed. We only hoped we could satisfy the demand. The change to the dry method was already complete. No more summer harvest, no more unforeseen problems with the perishing green plants. Four more extraction tanks were ready. A barn for storing the poppy straw was built. For the deliveries, the railway laid a siding right into it. The chopper and the boilerhouse were enlarged.

Janos was in his element and really satisfied. The summer was spent in continuous work, but, after the times of forced idleness, that was real joy.

There was a good playmate minding the children, and the yard was filled with laughter. In the place of the chicken run, we planted a flower garden.

You must never forget the freedom and the boundless love that surrounded you in the Alkaloida plant at Budszentmihaly. Those two little rooms — the hall that we mockingly called the children's room, where the draft under the doors lifted the rugs, and the bedroom which on early winter morning was so cold we shivered when lighting the fire before you got up. In the summer, it was hot like a boiler from the fuel stove in the adjoining kitchen.

By the end of the summer, all the construction was finished; the plant was ready for 500 kg production. We had an assistant now, a local pharmacy student who took the worry of the titrations off our shoulders. Still, the work load did not decrease. The administration expanded, the correspondence with the growers was unending, and so were the business trips.

The crystallization and purification were perfected. The two of us performed this final part of the production every day. Janos designed an implement to cut the two kg of finished product each day into small cubes. The quality was first class. "It is better than the Merck's" was the usual tribute from all customers.

Our happiness would have been complete, except that Janoska was coughing incessantly and could not take the dusty climate. We should have had his tonsils operated on, but there was no money for anything personal yet. So, night after night, we listened helplessly to his choking spasms. I was not healthy either. When pulverizing the morphine, it was impossible to avoid breathing the dust. There are people who develop difficulty breathing, coughs, and skin rashes. For a sensitive person like me, there was only one solution. I had to leave the lab.

September, 1933

Janoska was already a schoolboy. Now, it was Icike's turn. This summer our health was better also, boosting our hopes.

Everything was organized, and the work went according to plans. Oh, we always had hurdles — times we did not get coal or sodium bisulphite for extraction, the poppy straw deliveries were late, and money was always short and understanding even shorter. Twice, the extract fermented, and we lost it. The first time because of the cheap liquid sulphite forced on us. Then, the straw contained too much of the partly dried leaves. The production dropped, and it was very difficult to re-establish it.

By the end of the year, one more hard trial waited for us: the government forced us to produce codeine.

Janos' objections were in vain. The process with dimethylsulphate was outdated and commercially not viable; for a price, one could purchase not only the tested modern method but equipment also. The state refused the finance, but had to have the codeine. The international companies from whom, until then, they obtained it in exchange for our morphine, stopped supplying, Our protest was looked upon as sabotage by the minister, and he ordered Janos immediately to start the transforming, without government money.

We began the methylation in glass dishes, crying for each gram of morphine sacrificed for codeine. Our original method was created for qualitiative purposes only; the process was reversible and, without modern equipment, we could not prevent disintegration: 50% to 60% of the starting material was lost during the slow, complicated operation.

For the losses, Janos had to explain to the bureaucrats that without investment the whole project was impossible. Finally, they relented and renegotiated the exchange. But, nothing could compensate for the bitter hurt and the degradation.

Janos was also worn out by the struggle and the anxiety. His heart, that big heart, often tormented him; at times his whole left side was numb, almost paralyzed. But, time after time, he concealed the ebbing force. Everybody believed this transparent mask. Janos Kabay was strong, his shoulders could carry all the load.

Spring, 1934

We again had momentum in the company. With a large-scale order from Denmark, we began to expand the plant again and decided to open a factory in Poland.

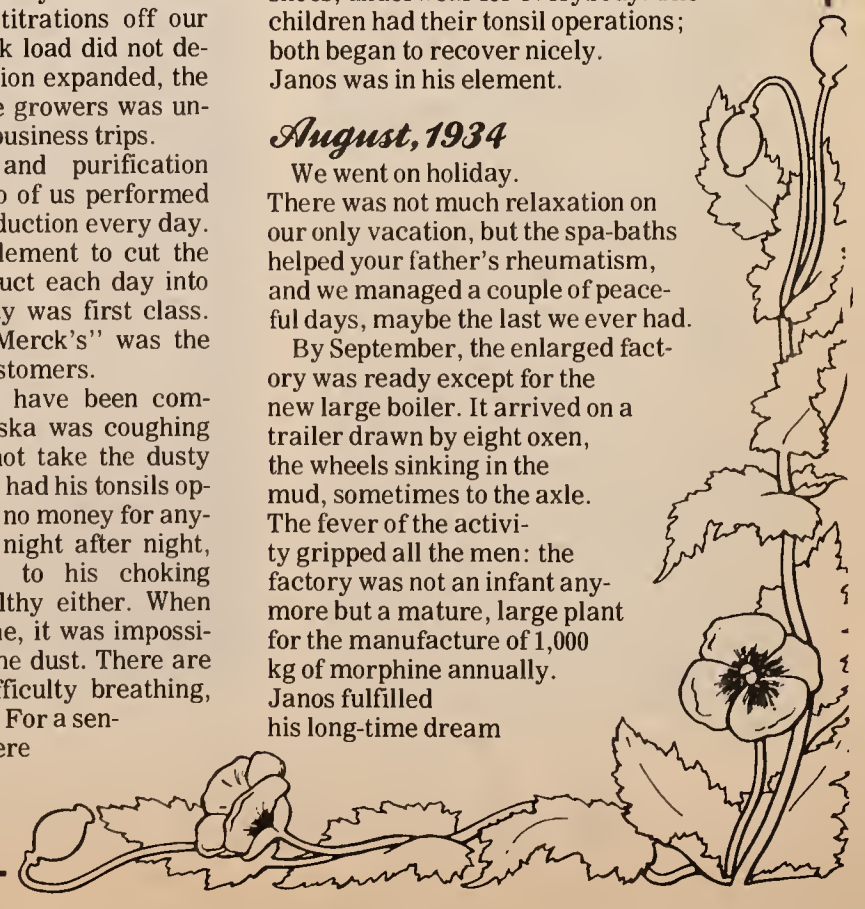
The Narcotic Drug Control Committee of the League of Nations invited your father to Geneva to present his invention to the Assembly. There, he was rewarded by the respect and esteem of scientists that he never received at home. The honor and recognition was acclaimed by the European press, and there followed recognition in Hungarian circles.

The seven lean years appeared to be over. Our third child could stand on its own feet. At last, we could take care of the other two. We went shopping. Good clothes, shoes, underwear for everybody. The children had their tonsil operations; both began to recover nicely. Janos was in his element.

August, 1934

We went on holiday.
There was not much relaxation on our only vacation, but the spa-baths helped your father's rheumatism, and we managed a couple of peaceful days, maybe the last we ever had.

By September, the enlarged factory was ready except for the new large boiler. It arrived on a trailer drawn by eight oxen, the wheels sinking in the mud, sometimes to the axle. The fever of the activity gripped all the men: the factory was not an infant anymore but a mature, large plant for the manufacture of 1,000 kg of morphine annually. Janos fulfilled his long-time dream



The Kabay Diary

and built the workers' canteen and dressing rooms, the first in Eastern Hungary.

Our little home was enlarged also. The kitchen and pantry were moved into a separate building, and Janos built a nice, airy children's room, furnished with lovely white furniture. The open verandah was glassed in; garden furniture made it our sunny retreat.

We were delighted that finally we would have a comfortable home. With how much love we furnished it, so when the children returned everything should be perfect. How it would have hurt if we had known it was to be ours for only half a year and that we prepared for someone else all the comfort we did without for so long.

We hoped all we had to do was organize the production and the bookkeeping and teach the new employees. Your father was exhausted, worked to death already. He had accomplished the impossible: the economical production of morphine. He deserved appreciation and a little rest.

But, autumn, 1934 brought staggering news: we could not export the raw morphine for which the whole plant was extended! It was against the interest of the foreign opium producers that cheaper and purer morphine should reach the international market. The Geneva Narcotic Bureau expressed its intention of limiting our capacity, amazingly blaming the illegal drug trade. The Morphine Cartel, all big multinational companies and our original adversary, prevented us from getting the import licence in Denmark. We had to deliver in codeine. In codeine! When everybody knew we were not fitted out for the methylation and our existing method, transformation with dimethylsulphate, meant the loss of half the raw morphine. The renovated factory was wholly equipped for the manufacture of raw morphine. We could not even think of any more equipment, capital, or credit.

Janos protested. He had to attempt the impossible again. We had to deliver the codeine to Denmark or risk losing the international prestige built up with so much sacrifice.

Where were the partners from the city office, the co-authors, advisers, and shareholders? Everybody withdrew silently.

I could only stand beside Janos, looking on helplessly as he fought. Sick as he was, with shattered nerves, but with clear, exploring mind, he searched for a way. Experiment followed experiment; more and more expensive material was wasted.

Finally, there was codeine. The patient was successfully saved, but the doctor collapsed.

The codeine method was improved to 75%; we had codeine phosphate and hydrate. The crystallization of each was a separate problem.

The many partners came out of hiding, relieved. But, there was no praise. We were three months behind schedule and had lost 50 kg of morphine in the trials. All they wanted to know was: who will take responsibility for it?

Something broke in your father then. It was enough. Just let's get out of here, from this hell, where there is no stopping and no recognition.

January, 1935

Janos announced his decision to hand over the factory's management to his brother, Peter. We would move to Budapest to work on further projects. In my heart, I was afraid that if I protested he would think I wanted him to keep on driving himself. I knew our health and nerves were not suitable for such dramatic decisions. I begged my doctor brother-in-law, Joska, to recommend sick leave to Janos. Two, three months rest was what he needed. Let Peter take care of the plant in between and, after that, we should decide about our future. Nobody listened.

But, everybody picked up Janos' idea. How perfect! The work is finished, the plant running smoothly, Peter should have it. The firstborn son would be in the most important position. What would Janos do? Where would he find work, scope for his abilities? Nobody asked.

Straight away, all arrangements were made to exchange the homes. We would take over Peter's in Budapest, and they would move into our new little home that we built with so much love.

Once, before the exchange was finalized, Janos realized what he had done. He could see the future clearly and knew that he should reverse what he had started.

Numbly, we lay through dark, dreamless nights with freezing hearts, trying to console each other. "You will see sweetheart, everything will be fine. We will work together in a little laboratorium; we will go through the chemistry again, work out a method to determine the alkaloid content of the poppy, to enable us to control the production."

Then, the mask dropped, and both of us shook with choking sobs as desperation tore at our hearts.

Easter, 1935

We said goodbye to the men in the factory yard. How much heartache and pain was in that parting. Big strong men sobbed as they embraced us and kissed the children. We all knew that the farewell was final, that what we had was lost forever.

In Budapest, the first night, Janos was very sick. But, he recovered, and we started to hope again, planning our new lab, starting to read and study again, something we could not do under the pressures of the years past. Janos often talked about his plans for our future.

Mid-1935 saw the building and equipping of the Polish factory. Janos' letters from his four journeys to Warsaw are my treasure. They radiate calm strength and boundless love. The organizing of the plant was a very tiring task. He had to start everything at the beginning, but he could sense respect and friendliness. He wrote in one of his last letters: "Hurts to know that every minute we spend far away from each other won't ever return, and we will be poorer by it."

After we left it, the factory went smoothly for a couple of months; with everything organized, it performed nicely. Later on, there were daily complaints against the product quality. The Kabay morphine and codeine which had been known to be first class, started to slip to second rate. One of the supervisors wrote to us: "Everything is not as it should be, Mr President (that was Janos' title then). You should come back and look into the changes." But, Peter did not listen to criticism and did not even let Janos in the factory.

In November, Janos again attempted to regain the factory, feeling it was necessary for the company. He made an offer to Peter that was rejected by the whole family. Janos was staggered. It hurt that nobody understood what was at stake.

December, 1935

Exhausted, he had to go to Poland again. He was away three long weeks and solved the remaining problems.

Every night, I waited beside the telephone. I felt he was sick, though he did not mention it. But, from overwork and much strain, his emaciated body was racked by an acute hernia attack. The hernia had originated in early childhood and had bothered him over the years, but he did not let them operate. In Poland, the doctors treated him, but warned if it occurred again, it had to be operated on within three hours. When he left by car, the good Polish medicos contacted every airport on his way home so that if it was necessary he could be flown back to Warsaw to be operated on by their best surgeon. I wish they would have done it.

He returned before Christmas and decided to go to hospital in January. We were all together for Christmas Eve. With how much love did your father decorate the huge tree.

After Christmas, he worked on establishing the laboratorium. As part of this program, we had to perfect the codeine transformation, apply for the German patent, put in print the analysis of the poppy's alkaloid content, and work out methods for the alkaloid derivatives.

We had many big plans to enrich our life. Trips abroad; a new factory in Czechoslovakia. The program was vast.

But first, he wanted to be strong and healthy again. After the hernia operation, he planned to check out his stomach and fix up his teeth. And maybe even let them straighten out his nose, the memento of a student boxing match.

February, he will be resting. I will manage the lab. From then on, we work together. The children are in a good school, they have a German governess. Our cook can look after the household. We can truly become scientific researchers.

18th January, 1936

Janos had another hernia attack. In desperation, we called three doctors. One recommended the Whitecross hospital, another, the Redcross, where the surgeon had an excellent name. To our peril, we chose the latter one. On the 21st January, we went to the laboratorium. In the afternoon on the way to the hospital, we stopped at a little coffeeshop. Then came the hospital and the end.

On the 22nd, the operation was carried out. According to the surgeon, it was child's play and successful.

24th January, 1936

Janos received the transpulmin injection which caused the fatal infection. On Saturday, we brought it to the professor's attention that the needle mark was red and swollen. At night-time, he had already a high temperature, but it was only noon the next day when the bandage was changed.

It was too late. The poisoning had spread through his abdomen. They operated on him again, without anesthetic, cutting out the affected parts, needlessly causing him horrible suffering.

29th January, 1936

He left us. Maybe with penicillin, which was already invented, they could have saved him. But, it was not yet known or used in Hungary. He was conscious to the last minute, even if he could not talk in the last eight or 10 hours. His eyes flew to the door whenever it opened. I am certain he was expecting his mother till the last, but in vain. His mother was with Janos' sister who was also critically ill with pneumonia. Valika, the only one who never turned against him, died 20 hours after Janos.

1st February, 1936

We buried him in the Farkasreti Cemetery. Six of the oldest workers came to carry the casket, but the factory was not allowed to stop. The press paid homage to him right across the country; we fête our great ones only when they are dead.

With Janos gone, my work was finished also, the sacrifice was complete. The countless plans collapsed.

On a heavenly star, maybe you, Janos, are already building your factory, the real one, that nobody can take away from you; preparing for me a little corner where we can once again work together, when God allows me to follow you.

Till then, I stand on the side of the road with my empty life, vainly questioning fate, because I won't understand ever the ways of justice on this earth. I did not die, but my life's light and richness is lost. In the emptiness, only the spark of faith holds the hope of reunion.

Postscript

By John J. Kabay

The name of Janos Kabay is revered in today's Hungary. Streets, societies are called after him, monuments erected. They made a hero of him.

We don't know whether it was for his love and care for his workers, with whom he shared all their misery, or maybe for his battles in the previous system. His surviving friends and colleagues love him for what he really was: a man with a mission, who, in spite of his genius, always remained humble, caring, a true Christian.

The Alkaloida factory was nationalized after the war. It is today one of Eastern Europe's largest pharmaceutical concerns, exporting all over the world, giving security to 3,000 people in Hungary's poorest quarter, as he wanted it, creating jobs in the town of his fathers.

The opium alkaloid produced by the factory, with far more modern equipment, is basically still the Kabay method, and so is the process most big companies use all over the world, even if its origins are denied and the inventor's name forgotten.

He wanted to give his children the world.

Our material heritage, beside yellowing photos and patents and a diminishing number of friends who knew them and keep them in their memory, is a far-away plot where they finally rest together. Even that is cared for by strangers.

The true heritage is in the clear eyes of their grandchildren, whose love of family, pride in their work, purposeful life is a monument more durable than stone.

We know who our father was, and our mother also.

The two of them, who were torn apart so cruelly long ago, will live treasured, undivided, in our memory. Always together.

Sydney, 1984.

In Tasmania: (left to right) Roger Groom, Ilona Kabay Oltvanyi, Frank Potts, John Kabay

The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada, M5S 2S1

Biomedical research on alcohol: an update

3rd Congress of the International Society for Biomedical Research on Alcoholism

Research into alcohol and the multiplicity of its actions in animal models and, most importantly, humans has burgeoned in recent decades.

But, many questions still puzzle scientists around the world, despite increased awareness of the biological mechanisms, allied with technological advances. Many of these researchers, from North America, Western Europe, and Japan, attended the 3rd congress of the fledgling International Society for Biomedical Research on Alcoholism (ISBRA), held at the University of Helsinki. (See Advances, p1.)

The society is decidedly multinational: the 1984 congress was held in Santa Fe, New Mexico, and the 1988 congress will be in Kyoto, Japan.

The 1986 congress was co-sponsored by Alko, the Finnish state alcohol monopoly, whose activities vary from long-term research, including developing the Alko rat model, to producing the very successful promotion abroad of Finlandia vodka.

The variety of congress presentations was vast, ranging across historical evidence of drinking patterns, genetics, tolerance, intoxication, sex differences, fetal alcohol syndrome, and the search for a sobering-up agent, as Washington contributing editor Harvey McConnell reports.

'Consumption fluctuations are surprisingly common among industrialized countries'

An historical perspective of alcohol use and abuse in industrialized countries shows considerable fluctuations in consumption and presents some remarkable conclusions, Klaus Makela, of Alko (the Finnish State Alcohol Company), declared in launching the conference sessions.

The first is that fluctuations are surprisingly common among countries despite differences in each nation's general economic development and its internal alcohol culture.

Secondly, "none of the factors commonly put forward for the explanation of drinking or problematic drinking, such as buying power, the amount of leisure time available, social misery, industrialization, or growth of the urban areas, presents patterns or variations over time similar to the variations in alcohol consumption," Dr Makela added.

The end of the 19th century saw rapid accumulation of wealth, but the consumption of spirits dropped. Leisure time expanded rapidly in the years between the World Wars, but this did not induce people to drink more.

Dr Makela: "Long waves of alcohol consumption are linked to complex historical processes and cannot be explained by simple factors or combinations of factors." It could be that the alcohol consumption level is determined by the level of detrimental consequences of drinking which a particular culture, society, or era can tolerate.

Between 1945 and 1970, alcohol consumption increased in every country which has provided reasonably accurate statistics, and some countries approached the peak levels reached in the mid-19th century. The fastest growth was in countries which started at a low level; the gap between the highest and lowest consuming nations narrowed, although strong national differences in the choice of the type of alcohol remain.

Dr Makela noted that private drinking has increased, particularly in countries with a history of drinking in public; this can be partly attributed to a decline in traditional praetices imbedded in largely rural communities. And, some of the change is due to new drinking populations, especially women and teenagers.

The rise in consumption started either to slow down in some countries or decrease in others from the early 1970s. But, consumption continued to increase in many Third World countries, some Communist countries, and Luxembourg and Denmark.

Along with increased alcohol consumption after World War II came changes in perceptions of related problems and how to handle them. "The most pervasive expansion of services for the heavy drinkers are organized and financed under the medical rubric," Dr Makela noted. Much of this is due now to international professional influences, with common solutions being attempted for very different problems.

Dr Makela concluded that "the bulk of alcohol damage may well be experienced by non-dependent drinkers who may not need specific treatment, unless under 'treatment' we don't include simple advice, admonishment, and even price policy."

'Alcoholism is more a political problem than a medical problem'

Michael Bohman, department of child psychiatry, Umea University, Sweden, in reviewing population studies, said: "Alcoholism is more a political than a medical problem." He and his colleagues are engaged in a continuing study of alcohol abusers in Stockholm. They have found only a combination of genetic and environmental backgrounds leads to an increase in alcohol abuse; other combinations do not.

They conclude that in considering different genetic backgrounds there is no one genetic fact involved in alcohol abuse: it is probably many factors on many different biological and psychological levels.

Dr Bohman: "The increased level of consumption in the post-war period has raised the risk of social and medical complications to alarming levels. Changes in pricing and economic conditions have probably been a major cause for the dramatic increase in consumption and complications."

Brain waves and hormone levels might — and might not — lead to elucidation of biological markers which can identify children with increased risk of developing alcohol problems in later life.

'The premise is to search for potential physiological markers for high risk groups'

Henri Begleiter, State University of New York College of Medicine, said research over the past decade by him and his colleagues and others, plus various replications, shows promise.

He pointed out the premise in looking at high-risk populations — sons of alcoholic fathers — is to search for potential physiological markers, aberrations or deficits found in abstinent chronic alcoholics. Out of this has grown a study of brain stem-evoked potential measuring milli-second to milli-second what is happening in the brain. They have found some electro-physiological deficits in sons of alcoholics also observed in abstinent alcoholics.

Dr Begleiter said in one main study 23 sons of alcoholics and matched-age controls were tested with tone signals at varying frequencies and duration, interspersed with an infrequent tone to which the subjects reacted by pressing a button. They found a large difference in response between high- and low-risk groups, and they have replicated this with a different paradigm.

He said some of their recent data analyzed by scientists at the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA) show the low-risk group habituates at a much faster pace than the high-risk group, "that there is some form of learning deficit, if you will."

Dr Begleiter: "One might postulate that some of these high-risk kids might have a problem in passive avoidance, which is a task highly influenced by the frontal lobes. We have replicated our findings and we know the data appear to be somewhat reliable. As to the validity and the exact significance of these data, I think we will have to wait for future research."

'Prolactin — too much variability to be the most wonderful marker'

Measuring hormone changes has both assets and liabilities, said Marc Schuckit, University of California, San Diego, and Veterans Administration Medical Center, who has for some time studied prolactin and cortisol release following an ethanol challenge in sons of alcoholics and matched controls.

He and his colleagues picked sons of alcoholics who are already social drinkers, in the hope they can follow them in the future to see who might become alcoholic.

His studies have included subjective assessment — sons of fathers who are not alcoholic report a greater intensity of reaction to alcohol — and more objective measurements of cognitive and psychomotor performance. In some tests, there is little or no change, but, overall, if there is a decrement in performance, it is, again, higher in sons whose fathers are not alcoholic.

In the prolactin studies, they have found little difference in levels when both groups are given placebo. But, with low doses of ethanol, compared with placebo, there is a significant increase in prolactin release among controls but not sons of alcoholics. With high doses of ethanol, although both groups have a significant prolactin response, there is still a marked difference.

Dr Schuckit: "What is going on with prolactin is not as strong as one would like to see. If you were to say, 'Give me a marker that I think I can use as a biological marker of intensity of reaction,' then prolactin has too much variability in it to be the most wonderful marker. But, it is consistent with other data of significant difference between groups."

'The rats meet all the perceived requirements for an animal model'

Ting-Kai Li, 1986 recipient of the Jellinek memorial award (see page 9), outlined his research at the Indiana University School of Medicine, Indianapolis, into breeding, after 16 generations, rats which prefer alcohol (P) and those who do not prefer alcohol (NP). They are satisfied that the P rats meet all the perceived requirements for an animal model.

Dr Li noted that voluntary alcohol consumption is an essential feature of any animal model, but the problem is to get the animal to prefer alcohol, at medium and high doses, over water.

Their P rats voluntarily drink alcoholic solutions to intoxication, will bar press to obtain it, acquire metabolic and neuronal tolerance, develop physical dependence, and will self-administer alcohol intragastrically.

Dr Li: "It is axiomatic that the degree to which an animal model can approach the human condition depends on how you define it. Alcoholism in humans is now known to have both psychosocial and biological, or genetic, risk factors. The nature of these risk factors and how they interact still requires definition. But, all of them are expressed through a final common behavioral pathway, abnormally intense, alcohol-seeking behavior, which, over time, leads to loss of control over drinking, increased misbehavior, tolerance, and physical dependence."

He and his colleagues have found the P rats drink episodically, not continually, and will stop drinking when blood alcohol concentrations reach 0.05% to 0.07%. If deprived, then put into a cage with both alcohol and water, the P rats will drink as much alcohol in one episode as they would usually consume over a 24-hour period.

The genetic background of the animals is very important in studying self-administration of alcohol. With their models, the researchers can show that alcohol at low doses is reinforcing and that at high doses it is aversive.

Dr Li said in animals "we believe that the low-dose reinforcing effect, as well as the persistence of acute tolerance development, is a very powerful combination, and that this is something worth looking at in the future, in terms of brain reward systems and in terms of the neurochemical or neurohumoral kind of responses to alcohol."

Looking at the different kinds of animal models to see what kind of genetic relationship is most enduring with respect to alcohol preference, one would have to agree it is acute tolerance development, he added.

'Understanding tolerance requires an appreciation of environmental influences'

As for tolerance, a body of research from many laboratories shows environmental influences cannot be ignored, says Shepard Siegel, professor of psychology at McMaster University, Hamilton, Ontario.

He pointed out most theories of tolerance "stress the physiological consequences of repeated drug administration: some systemic change within the organism that decreases receptor sensitivity to the drug, or induces some neurochemical change, or alters the metabolism of the drug.

"But, it has become apparent in recent years that a complete account of tolerance requires an appreciation of not only pharmacodynamic and pharmacokinetic principles, but also environmental influences."

This Pavlovian conditioning has been demonstrated in numerous trials with animals: tolerance occurs if the animal expects the drug, but not if the animal does not expect the drug.

"When a drug is administered over and over again, as Pavlov indicated, the environmental cues that are present at the time of administration become associated with the systemic effects of the drug, and as the drug is administered more and more often, the association between drug signaling, environmental cues, and systemic effects get stronger."

It can be demonstrated that animals and humans have learned such an association.

Dr Siegel: "I don't wish to suggest there is a conditioning analysis of tolerance and there is another analysis of tolerance that has nothing to do with conditioning, that is completely independent. In fact, the conditioning analysis of tolerance is not an alternative to traditional interpretations, rather it is complementary to the views of tolerance that do not acknowledge a role of learning."

'Not all behaviors become tolerant. Genetics plays an important role'

Boris Tabakoff, who has carried out various studies into tolerance at the NIAAA, said one reason for tackling this vast subject is to try to understand both the general neuro-adaptive processes that take place in the brain and are responsible not only for tolerance, but also other forms of adaptation such as learning, and some of the processes that result in increased intake of alcohol. Tolerance may be important in this process.

3rd Congress of the International Society for Biomedical Research on Alcoholism

In acting on Dr Siegel's experiments, their own at NIAAA, and those of others, Dr Tabakoff said they are trying to divide tolerance into components — although they do not think these components are mutually exclusive — in order to construct experiments that may lead to understanding the mechanisms that provide development of tolerance.

Studies have shown tolerance is multifaceted and involves aspects of learning and conditioning as well as molecular changes in the structure of neurons in the central nervous system. An animal may use different strategies under different conditions to try to resist exposure to ethanol.

Tolerance does not develop to all behavior. Genetics plays an important role in the extent and rate of tolerance development.

Dr Tabakoff said it has been shown the presence of alcohol in the brain is necessary, but not a sufficient criterion.

"In other words, in animals exposed to ethanol in whom the noradrenergic systems were destroyed, tolerance did not develop. Thus, the activity of particular neuronal systems, and this includes both the noradrenergic and the serotonergic systems, is necessary in the development of tolerance."

'It is important to control for age, demands of sleep, gender'

As tolerance can vary, so can alcohol intoxication in humans, Markku Linnoila, a Finn who is currently at the NIAAA, pointed out.

In any studies about alcohol intoxication, "it is very important to control for age, it is very important to control for demands of sleep — if we manipulate the amount of sleep, we can manipulate the effects of alcohol rather dramatically — and it is very important to control for gender. In any studies of women, particularly at low blood alcohol concentrations, it is extremely important to control for the phase of the menstrual cycle."

Dr Linnoila noted previous studies have found that the highest risk of fatal traffic acidents is among male drivers aged 16 to 19 years. In this group, there is a striking difference in performance at relatively low blood alcohol concentrations.

Alcohol's effect on motor responses is fairly minor, but there is a major impact on gathering of information.

Dr Linnoila: "A skilled driver fixes well ahead on the roadway when sober, trying to pick up trouble spots which may arise. When drunk, and not very drunk at a level of around 0.07% BAC, he begins to sample information remarkably close to the hood of the car and in no way can pick up something dangerous happening where he usually samples."

Effects of alcohol increase the time needed to process information, and while an individual may retain his speed of response, his accuracy in responding is decreased.

Dr Linnoila said while there are far fewer females who drive drunk, "at every alcohol level, the females are at the higher risk of being in a crash. The differences are quite remarkable."

When studies are made of alcohol's effects in different phases of the menstrual cycle, he continued, alcohol appears more sedative in the woman at the low dose during the luteal than the follicular phase.

Dr Linnoila said that during the phases of the menstrual cycle the two brain hemispheres are differently activated by alcohol. There is now a large body of psychiatric literature, and the primary contributor has been Pierre Flor-Henry from Canada, suggesting that the differential activation in the brain is very important for affective states. In depression and affective disorders, there is more right-sided activation, and in schizophrenic disorders, left-sided activation.

The suggestion is that in women, there is a very strong menstrual cycle interaction at low doses on the mood effects of alcohol, and, in certain circumstances, alcohol raises the levels of anxiety.

'Can alcohol elicit transient changes in circulating hormones?'

While the effects of chronic alcohol consumption have been known for a long time to interfere with sexual behavior and reproductive function, it is only recently that investigation has been made into the effect of alcohol on sex hormones.

James Ellingboe, of the McLean Hospital-Harvard Medical School, said that in men, ethanol doses can suppress plasma testosterone by direct inhibition of testicular steroid synthesis, while plasma levels of luteinizing hormone (LH) rise slightly, if at all.

In women with normal menstrual cycles, acute ethanol alcohol administration does not appear to change plasma estradiol or LH, and LH is not effected in postmenopausal women.

Dr Ellingboe added that while it is well-known that prolonged alcohol consumption is dangerous to the developing fetus, there is considerable uncertainty about the effects of acute alcohol ingestion by pregnant women.

"We would like to know if alcohol could elicit transient changes in circulating hormones. It might have critical effects at certain stages of fetal development," Dr Ellingboe added. More information is also needed about the possible hormone determinants of effects of alcohol on the libido, aggression, and violent behavior.

'Alcohol and brain damage is one of the most under-researched areas'

One of the most under-researched areas, and a very complicated one, is alcohol and brain damage. Peter Carlen, of the Addiction Research Foundation, Toronto, said: "I do not know of any good epidemiological study on the incidence of alcohol-induced brain disease."

One statistic he recently ran across indicated that for every two patients with Alzheimer's disease in chronic care institutions, there is one alcoholic. Yet, those with Alzheimer's disease tend to die within three years, while alcoholics have a long life span once they get into chronic care institutions.

Dr Carlen said his long-term studies at the ARF with colleague neuropsychologist Adrian Wilkinson show that if one wanted to use cerebral atrophy as a measure of alcohol-induced brain damage, then almost all of the subjects studied have evidence of this on various measures.

There is a tremendous variation in brain damage as assessed by neuropsychological examination and by CT scans, and age is a confounding variable. Other confounding variables are: family history of alcoholism, drinking history, concomitant liver disease, cerebral trauma, age, sex, and measurement errors.

Dr Carlen said there may be a correlation between liver disease and brain disease: patients with liver disease tend to have more neuropsychological impairment than alcoholics without liver disease. Links between diet, cerebral atrophy, and brain disease have not been worked out. "We don't know what is the dietary concomitant of alcohol-induced brain damage," Dr Carlen added. "Is drinking alcohol sufficient?"

He said his clinical experience is that alcoholics who tend not to feed themselves well are more likely to develop Korsakoff's syndrome. While genetic factors more than likely play a role in alcohol-induced brain damage, consideration should be given to other factors such as cerebral trauma. "Alcoholics suffer a lot more cerebral trauma than other people, and how this relates to brain damage and brain dysfunction, we don't know."

'Alcohol may be the most frequent avoidable cause of hypertension'

On alcohol and the heart, Arthur Klatsky, Kaiser Permanente Medical Center, Oakland, California, said: "One cannot make any generalization about alcohol being good for the cardiovascular system or bad for the cardiovascular system." On the other hand, with the present state of knowledge, many people want guidelines.

Dr Klatsky said evidence has accumulated over 150 years that high alcohol intake by susceptible people can lead to alcoholic heart disease, or alcoholic cardiomyopathy. While thiamine deficiency has been identified as a factor in cardiomyopathy in the Orient, today it is fair to say that thiamine deficiency has very little, if any, proven role in cardiomyopathy due to alcohol among Western societies.

On alcohol and hypertension, Dr Klatsky said: "I will make a provocative statement. I think this may be the most frequent avoidable cause of hypertension." He thinks empirical evidence from population studies is becoming stronger, although the causality has not been proven because the mechanism has not been established.

There are now a substantial number of population studies which show an inverse relationship between alcohol use and coronary disease. There is some dispute about the shape of this relationship.

Dr Klatsky said there are two plausible mechanisms for the inverse risk. One is the high density lipoprotein (HDL) hypothesis that alcohol does raise HDL levels, and a high HDL does seem to protect against coronary disease. "Although that has not been established, I think it is likely to be involved." The second factor is that there is some evidence of an anti-clotting effects of alcohol.

Dr Klatsky pointed out reductions of risks occur in lower-drinking populations. As well, the obvious adverse effects of heavier drinking, including cardiomyopathy and raised blood pressure, "are certainly powerful arguments against heavier drinking, and it is certainly not justified for prevention of coronary disease."

'Even moderate doses result in definite changes in plasma lipoprotein pattern'

Research by Matti Valimaki and colleagues at the University of Helsinki has shown regular use of even moderate doses of alcohol results in definite changes of plasma lipoprotein pattern. The study was in 10 healthy volunteers given 30 grams or 60g of alcohol a day during two different three-week periods, separated by an abstinence period of three weeks. Lipoproteins were studied two and three weeks following each regimen.

Dr Valimaki said the smaller alcohol dose caused a significant increase of the apo A-I and apo A-II levels, but no change in HDL cholesterol or in other lipoprotein lipid levels. The higher dose, however, was accompanied by an increase of total triglyceride, total cholesterol, VLDL triglyceride, LDL cholesterol, HDL-2 cholesterol, HDL-3 cholesterol, apo A-I, and apo A-II levels.

'FAS only occurs in offspring born to chronic alcohol abusing women'

Biologically, children born to chronic alcoholic mothers outgrow some of the initial fetal alcohol syndrome malformations; mentally, they seem to be handicapped to some degree.

Carrie Randall, Medical University of South Carolina and Veterans Administration Center, Charleston, South Carolina, pointed out, in assessing a decade of research, that FAS only occurs in offspring born to chronic alcohol abusing women. The panoply of malformations, growth retardation, and central nervous system problems results from drinking during the first trimester through the third trimester. Women who do not drink entirely through pregnancy can have offspring with some of the effects of FAS, but not all.

'Long-term follow-up of FAS shows psychological variances'

Follow-up studies have shown the physical appearances of FAS children become more normal as they grow older. But, growth is still below average, and there are a number of psychological variances remaining.

Some have been found by Hans Spohr, University of Berlin, in long-term follow-up of children. The follow-up studies included a battery of both physiological and psychological assessments.

Dr Spohr: "Despite the apparent biological maturation, and improvement of overall psychiatric and cognitive functions, the group as a whole contained a remarkably high proportion of children with poor educational status.

"It is our impression that the persisting hyperactivity, together with mild mental retardation and distractability, contributed significantly to poor educational performance."

Dr Spohr said the children could well profit from counselling to overcome these developmental handicaps.

'Not everyone agrees an agent to sober up a social drinker is needed'

Because of the large number of deaths attributable to alcohol, an antagonist is needed. So far, none has been produced, and, if one is, a number of questions will be raised which will have to be answered.

Carlton Erickson, department of pharmacology, University of Texas at Austin, said he thinks eventually when an antagonist for the euphoric or sedative effects of alcohol is produced, it ought to be direct and affect the drug itself.

It should: be innocuous, have few side effects, be fast-acting so it could be used in emergency alcohol overdoses, and be pharmacologically dose-related — the higher the dose the better the effect.

But, there are important questions to be raised. "I think everyone agrees an agent which would reverse an alcohol-induced coma and respiratory depression would be useful," Dr Erickson declared.

"But, everyone does not agree an agent to sober up an intoxicated social drinker or an alcoholic would be useful."

Dr Erickson said some of the questions to be asked are whether a sobering agent should produce partial or complete reversal of alcohol's action; how long it should last; should it lower blood alcohol levels; how long before people can start drinking again; would alcoholics tend to drink more because they know a sobering up agent is available; will the antagonist itself be abused by people who go out and drink a lot because they know they can reverse the effects, and will they repeat again and again; and, should it be available to the public without a prescription?

One idea would be a molecule splitter drug.

Dr Erickson: "Wouldn't it be beautiful if the simple molecule of alcohol could be split into acetate, carbon dioxide, and water, all of which are innocuous in our body, and thereby instantaneously be reversed? I have set some of my chemist friends on this, and they have come up with a zero."

Another ideal would be to develop a drug which would bind ethanol immediately in the blood or organ and stop its action.

Lastly, there is the romantic notion that there may be a yet-undiscovered, folk remedy. One hears at times about North American Indian remedies which sober people up immediately, but there is no documented evidence. Yet, people continue to search.

INTERNATIONAL

Spectrometric technology arrives at sea and airports

Mobile unit can sniff out drugs, explosives

LONDON — A new, mobile, electronic "super-sniffer" system, capable of identifying drugs and explosives hidden in sealed baggage and cargo containers, has been developed for use in sea and airports, VIP facilities, and military installations vulnerable to terrorist attacks.

The venture, involving British Aerospace and Sciex of Canada, Thornhill, Ontario, has grown out of a larger project for the construction of fixed installations deploying a combination of the sniffer's mass spectrometry technology and a powerful X-ray detection system (**The Journal**, January).

A consortium of high-tech companies has already erected the world's first two automated port screening facilities at secret locations in the Middle East. Operation is to commence soon.

The simplified contraband detector uses mass spectrometry to identify vapors and particles given off by a broad spectrum of drugs and explosives. The makers of the system say each unit, costing about US $4 million (Cdn $5.5 million), is "capable of a 100% check of all containers passing through a medium-sized seaport."

The mobile unit is likely to emerge as a potent weapon against drug syndicates and terrorist organizations. And, it will speed the flow of commerce and reduce the cost of damage at cargo and customs checkpoints.

The mass spectrometer designed for the system by Sciex detects the specific emissions of atoms measurable when gases and vapors are electrically charged. The instrument is programmed to recognize the spectrometric "fingerprint" of drugs and explosives from vapors present even in the tiniest quantities.

Mass spectrometry is a highly skilled operation usually carried out by specialists in industry and at the universities. The new system is computer-controlled and has been adapted to the needs of routine cargo checks by trained operators.

The growth in the use of sealed freight containers has made the detection of contraband difficult. In most countries, cargo is examined manually and with dogs trained to sniff out drugs and explosives. Manual handling is slow, involving the unpacking and repacking of goods.

Cargo sniffer: one unit is capable of 100% check of containers, luggage, at medium-sized seaport

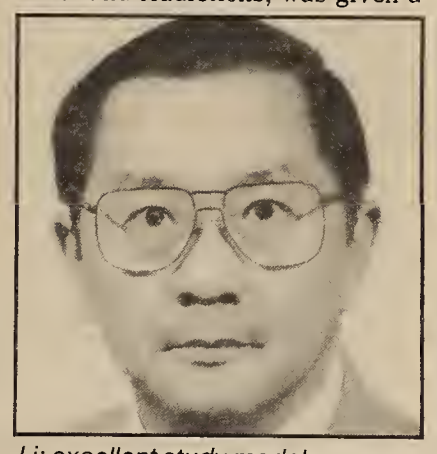
Jellinek honors presented to Ting-Kai Li, David Archibald

HELSINKI — Ting-Kai Li, MD, is the 1986 recipient of the Jellinek Memorial Award for his contribution to the advancement of knowledge in the alcohol field.

Dr Li is professor of medicine and biochemistry, Indiana University School of Medicine; associate chief of staff for research, Veterans Administration Medical Center; and, staff physician, University and VA hospitals, Indianapolis.

The award, presented here at the 3rd Congress of the International Society for Biomedical Research on Alcoholism, recognized Dr Li's discovery of a new type of alcohol dehydrogenase in human liver, the characterization of multiple allelic forms of alcohol dehydrogenase, and the demonstration and breeding of rat strains that have proved to be excellent models for the study of alcoholism.

In Budapest, in June, at the 32nd International Institute on the Prevention and Treatment of Alcoholism, H. David Archibald, president of the International Council on Alcohol and Addictions, was given a special Jellinek award citation.



Li: excellent study models

Archibald: understanding

The citation recognized Mr Archibald's outstanding achievement in founding the Addiction Research Foundation in Ontario (ARF) and "in developing it into a major research, education, and treatment centre with the highest scientific and professional standards."

The award recognized Mr Archibald's "profound understanding of the need for international cooperation in alleviating alcohol-relating problems and . . . his dedicated furtherance of these objectives, not only through the ARF, but also through his service to numerous other national and international bodies in the field."

HOWELL

Porn, drugs, and anti-science

There are many interesting parallels between the pornography industry and the illicit drug industry. It appears both are associated with the relative decadence (or freedom, if you like) of a society. In repressive societies, illicit drug use is usually a minor problem and the clandestine copying industry is usually devoted to materials of a political, rather than a pornographic, nature.

Like drugs, porn comes in 'hard' and 'soft' varieties. And, as with drugs, there is much discussion as to whether or not experience with the soft variety (*Penthouse* magazine is more or less the porn equivalent of marijuana) leads to a desire to experiment with the hard variety (many people consider kiddy porn, S and M, and snuff films to be the porn equivalent of heroin).

And, as with drugs, there is a great deal of theorizing, mainly on the basis of anecdotal evidence, as to the link between usage and behavior. Indeed, certain modern anti-porn tracts read like anti-drug tracts produced a half-century ago. But, this is from the February, 1986, issue of *Liberty Report*, a publication of the Liberty Foundation in the United States (formerly the Moral Majority):

"One night on his way home from work, Eddy stopped by at a convenience store to buy some lunch meat and a loaf of bread. Patty Sue was out of town with her parents. Eddy decided to buy one of those 'girly' magazines. Eddy says that he still remembers that night like it was yesterday . . . . Eddy found himself stopping by that same convenience store quite often on his way home. While he changed clothes and got ready to pick up Patty Sue, he would look through his latest purchase and get himself 'hopped up' on what was to become the seed that would one day produce a PORNOMANIAC . . . .

They found Mary Lynn in a ditch with a piece of tin thrown over her lifeless little body . . . . Now she was dead. She would never see another Christmas. Why? Because she was raped and murdered by a young man who, in 10 short years, had become a PORNOMANIAC. His name? Eddy!"

This reads like the script of the 1936 classic, *Reefer Madness*, a film produced when contemporary wisdom had it that marijuana was a Negro Plot to exploit White Women, every bit as insidious and dangerous as the Oriental Plot to enslave White Women by means of heroin.

Here we have another parallel, albeit an adverse one. The opposition to illicit drugs has slowly moved from hysteria about the machinations of minority groups, to scientific demonstrations of bodily harm.

But with porn, alleged scientific explorations of its effects, such as the 1970 American Commission on Obscenity and Pornography in the US (which concluded that there was no causal link between porn and sexual violence), have been followed by alleged scientific studies (such as the soon-to-be-released report of US Attorney General Edwin Meese's 11-member Commission on Pornography) that echo the hysteria of the 1920s.

Indeed, the anti-porn legislation recently proposed by former Canadian Justice Minister John Crosbie is so draconian in nature (strictly interpreted, it could be used to outlaw on-screen heterosexual kissing) that feminists, who were in good part responsible for instigating the legislation, are now vociferously objecting to it.

If there is a moral to be drawn from this, it is that we get the 'scientific evidence' the temper of the times demands. Imagine the kind of report on space shuttle safety that would have been written had it been commissioned after the SUCCESSFUL launch of the last mission; imagine the kind of report that would have been written had both Lee Harvey Oswald and Jack Ruby MISSED their targets. This is always something we should bear in mind.

In the 1930s, German scientists proved quite conclusively the inferiority of the Jewish race, which tickled the fancy of their leader who, not incidentally, had written: "The life of the people must be freed from the asphyxiating perfume of modern eroticism." In the 1930s, as well, Soviet scientist Trofim Lysenko proved quite conclusively, to the delight of Stalinist social engineers, that J.B. de Monet Lamarck was the true progenitor of genetic science, not Gregor Johann Mendel.

But, that was the 1930s. This is the 1980s. We're much more sophisticated now. At least, I hope so: with the ghosts of Anthony Comstock and Thomas Bowdler stalking the land in the guise of an attorney general and a justice minister pandering to that considerable percentage of the electorate that believes the world would be a better place if all books, with the exception of 'The Good Book,' were to be burned, I certainly hope so.

Don't get me wrong: I am not advocating a *laissez-faire* attitude toward porn anymore than I am advocating a casual attitude toward illicit drugs. Obviously, both have to be controlled by legislation to a certain extent. But, the essential question is 'to what extent?' What bothers me about the Meese-men is that, historically at any rate, their attempts to shield people like Eddy from hard-core porn generally fail. But, their attempts to get J.D. Salinger's *The Catcher in the Rye* banned from Eddy's high school library generally succeed.

By Wayne Howell

DEPARTMENTS

New Books

by MARGY CHAN

Pharmacological Adjuncts in Smoking Cessation

. . . edited by John Grabowski and Sharon M. Hall

There has been growing experimental and clinical use of pharmacological agents to control cigarette smokers' nicotine addiction. Several of the innovative experiments reported here are breaking new ground in the understanding of nicotine and smoking. The volume reviews and samples the most recent literature and scientific works.

"The findings point to the utility of integrating behavioral and pharmacological treatment strategies in tobacco dependence and have implications for the development of therapeutic interventions for other dependence disorders," says Jerome Jaffe, MD, former acting director, United States National Institute on Drug Abuse, in his forward to the book.

National Institute on Drug Abuse, NIDA Research Monograph: 53. Rockville, MD. 1985. 149 p.

Neurobiology of Alcohol Abuse

. . . by William J. Haugen Light

This is the second of a five-volume series, by the same author, that synthesizes and renders comprehensive the vast, scattered literature on alcoholism. Directed primarily to health care professionals, especially medical students, physicians, psychiatrists, and counsellors, the book begins with a review of basic neurobiology. It follows with more detailed discussions of the effects of alcohol and alcohol abuse on the human nervous system.

Other volumes in the series are: *Alcoholism: Its Natural History, Chemistry and General Metabolism; The Psychodynamics of Alcoholism; Alcoholism and Women, Genetics, Fetal Development and Polydrug Abuse; Alcoholism, Codependency, Recovery and the Role of the Clinician. Charles C. Thomas, Springfield, Illinois. 169 p. $26.75. ISBN 0-398-05197-6.*

Drugs and Alcohol

. . . edited by A. Carmi and S. Schneider

This is a collection of articles, case presentations, and research studies written by a number of international experts representing many disciplines in the drug and alcohol abuse field. The contributors focus on the more specialized interplay of psychological, ethical, and legal aspects of the problems. The monograph will be of help to professionals who deal with this difficult social problem.

Springer-Verlag New York, NY, Medicolegal Library; 6. 1986. 220 p. $59.30. ISBN 3-540-15838-3.

Other books

Treating the Cocaine Abuser — David E. Smith and Donald R. Wesson (eds), 1985. This book provides a multidisciplinary, epidemiological, diagnostic, and treatment perspective on current patterns of cocaine abuse in the United States. Hazelden. Center City, MN. 90 p. ISBN 0-89486-279-0.

Tumbleweeds: A Therapist's Guide to Treatment of ACOAs — Paul J. Curtin, 1985. The book examines the issues of relationships. emotions, confrontation control, separation, evaluation. and departure. These issues are viewed in the context of their role in an ACOA's (adult child of an alcoholic) recovery through the vehicle of group therapy. Quotidien. Rockaway, New Jersey. 87 p. ISBN 0-934391-03-3.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Alcohol and You

Number: 742.
Subject heading: Alcohol/alcoholism overview.
Details: Four, 10-min filmstrips with audio tape.
Synopsis: Young people are urged to get as much information as possible about alcohol before deciding whether to use it. The filmstrips attempt to cover all forms of use and abuse, for example, social drinking, addictive drinking, and drinking and driving. Young people are urged not to drink until they are old enough to make an informed decision.
General evaluation: Poor (2.1). Although the recommended target audience is grade 4 to grade 8, the filmstrips aren't appropriate for these grades. The actors are mainly adults and the settings, for example, bars, are not generally part of the target audience's experience. The filmstrips have reduced educational value because they emphasize only one choice: not to drink. This ignores the reality that many young people use alcohol and do so especially under parental supervision.
Recommended use: With a resource person, the filmstrips could be used with some general adult audiences.

Get the Message

Number: 738.
Subject heading: Attitudes and values.
Time: 18 min.
Synopsis: Young people get messages about alcohol and other drugs from many sources: advertising, television, parents, older siblings, music, sports heroes, etc. A preteen host talks about these influences while other young people describe their feelings about the messages and the use of drugs. Young people should be aware these messages can influence their decisions. Many ways to have fun without using drugs should be explored.
General evaluation: Excellent (5.9). This contemporary, well-produced film could lead to good discussion about important influences in our lives and how to deal with them. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit young people eight to 11 years old. It would also help parents, teachers, and other adults understand what young people think about drugs.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

American Hospital Association Annual Meeting — Aug 4-6, Toronto, Ontario. Information: John McMahon, president, 840 N Lakeshore Dr, Chicago, Illinois 60611.

North American Congress on Employee Assistance Programs — Aug 5-8, Toronto, Ontario, Information: Diane Vella, 2154 Crooks Rd, Ste 103, Troy, Michigan 48084.

Canadian Woman's Christian Temperance Union Convention — Aug 11-15, Fredericton, New Brunswick. Information: A.H. Rawlins, Canadian WCTU, 875 Sunset Blvd, Woodstock, Ontario, N4S 4A5.

North American Indian Conference on Alcoholism and Drug Abuse — Aug 12-15, Cornwall, Ontario. Information: St Regis Drug and Alcohol Division, RR 3, Cornwall Island, ON K6H 5R7.

Canadian Society of Hospital Pharmacists 39th Annual Meeting — Aug 28-30, Ottawa, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

Canadian Society of Forensic Science Annual Conference — Sept 15-19, Niagara Falls, Ontario. Information: Executive secretary, Canadian Society of Forensic Science, 2660 Southvale Cres, Ste 215, Ottawa, ON K1B 4W5.

Fundamental Concepts — Sept 15-19, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

55th Annual Meeting of the Royal College of Physicians and Surgeons of Canada — Sept 21-25, Toronto, Ontario. Information: Pierrette Leonard, communications section, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, ON K1M 1P4.

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

Introductory Addictions Management Course — weekly, from Sept 24-Nov 26, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Orientation to Detoxication Services — Sept 29-Oct 3, Jan 26-30, 1987, April 27-May 1, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May Street, Toronto, ON M4W 2Y1.

Ontario Occupational Health Nurses' Association 1986 Conference — Sept 29-Oct 3, Sudbury, Ontario. Information: J.M. Martindale, publicity chairperson, c/o Inco Ltd, 38 Godrey Dr, PO Box 729, Copper Cliff, ON P0M 1N0.

The Troubled Employee: Intervention in the Workplace — Oct 1-3, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Workplace 86 — Beyond Awareness: Emerging Issues — Oct 1-3, Edmonton, Alberta. Information: Alberta Alcohol and Drug Abuse Commission, community education services, Ste 803, 10109-106 St, Edmonton, AB T5J 3L7.

American Association for Automotive Medicine Annual Meeting — Oct 6-8, Montreal, Quebec. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Addiction and Family Violence — Oct 18, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Counselling Communication Skills Course — Oct 27-31, March 5-April 23, 1987 and July 6-10, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Social Science Federation of Canada Research 86: Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario K1A 0N5.

Building Effective Employee Assistance Programs: Employee Benefit and Productivity Tools — Oct 29-30, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4R5.

15th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology — Nov 2-6, Quebec City, Quebec. Information: Mary Lynn Moffat, CAG/head office, 1080-167 Lombard Ave, Winnipeg, Manitoba R3B 0V3.

The Children of Alcoholics: A Canadian Conference for the Helping Professional — Nov 16-18, Toronto, Ontario. Information: Children of Alcoholics conference, PO Box 159, Station H, Toronto, ON M4C 5H9.

Event 86 — Skill Development and Training for Employee Assistance Personnel — Nov 16-20, Oakville, Ontario. Information: James Simon, Addiction Research Foundation, Georgian Bay Centre, PO Box 936, 100 Bell Farm Rd, Barrie, ON L4M 4Y6.

Drug Education Coordinating Council 4th Annual Conference — Nov 20-21, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

Canadian Addictions Foundation Annual General Meeting — Nov 21-22, Edmonton, Alberta. Information: CAF head office, 4254-93 St, Edmonton, AB T6E 5P5.

Group Therapy Course — Jan 19-23, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Pharmacology and Drug Abuse Course — Feb 2-5, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Perspectives on Employee Assistance Programming Course — Feb 16-19, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

The Community and Northern Justice — March 15-20, 1987, Whitehorse, Yukon. Information: Northern Conference Office, c/o continuing studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Drugs, Drug Abuse, and the School System — April 22-23, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

United States

1st National Conference on Alcohol and Drug Abuse Prevention: Sharing Knowledge for Action — Aug 3-6, Washington, DC. Information: Teddi Pensinger, National Institute on Alcohol Abuse and Alcoholism, prevention branch, 16-C-14, 5600 Fishers Ln, Rockville, Maryland 20857.

Chemical Dependency Nursing — Aug 4-15, San Diego, California. Information: University of California, San Diego, X-001, La Jolla, CA 92093.

Effective Assessment of Chemically Dependent Youth — Aug 5-7, Buffalo, New York. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

Annual Conference International Doctors in Alcoholics Anonymous — Aug 7-10, San Diego, California. Information: Lewis K. Reed, 1950 Volney Rd, Youngstown, Ohio 44511.

9th Annual North Carolina School for Alcohol and Drug Studies — Aug 11-15, Wilmington, North Carolina. Information: Office of special programs, University of North Carolina, 601 S College Rd, Wilmington, NC 28403-3297.

Midwest Conference on Alcoholism and the Family — Aug 17-21, Minneapolis, Minnesota. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Southeastern Conference on Prescription Drug Abuse — Aug 17-21, Athens, Georgia. Information: Sharon Shaw, 505 Deaderick St, 4th Fl, Nashville, Tennessee 37219-5393.

26th Annual Southeastern School of Alcohol and Drug Studies — Aug 17-22, Athens, Georgia. Information: Bill Johns, Georgia Center for Continuing Education, University of Georgia, Athens, GA 30602.

Assessing Adolescent Drug Abuse in the School Setting: Concepts, Tools, and Skills — Aug 19-21, Milwaukee, Wisconsin. Information: De Paul Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

1986 Illinois Institute on Drugs and Alcohol — Aug 24-28, St Charles, Illinois. Information: Emma Redmond, State of Illinois Center, 100 W Randolph, Ste 5-600, Chicago, IL 60601.

North American Congress on Alcohol and Drug Problems — Sept 7-11, Boston, Massachusetts. Information: Alcohol and Drug Problems Association, 444 N Capitol St NW, Ste 181, Washington, DC 20001.

New York State Council on Alcoholism Annual Meeting — Sept 18-19, Albany, New York. Information: Sherrie Gillette, New York State Council on Alcoholism, 155 Washington Ave, Albany NY 12210.

Children of Alcoholics — Sept 25-27, Chattanooga, Tennessee; Oct 16-18, Phoenix, Arizona; Nov 6-8, Houston, Texas; Nov 13-16, Los Angeles, California. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Alcohol-Related Birth Defects: Implications for Policy— Oct 19-21, San Diego, California. Information: Alcohol-Related Birth Defects Conference, University of California, San Diego X-001, La Jolla, CA 92093.

National Federation of Parents for Drug-Free Youth 5th Annual Conference, Networking America for Drug-Free Youth — Oct. 9-11, Washington, DC. Information: Mary Jo Green, 8730 Georgia Ave, Ste 200, Silver Spring, Maryland 20910.

Northeast Conference on Addictions: The Chemically Dependent Family — Oct 26-29, Albany, New York. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Improve Your Group Counselling: An Advanced Skill Building Seminar — Oct 28-30, Houston, Texas. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

The Age of Geriatric Rehabilitation Perspectives and Potentials — Oct 30-31, New Hyde Park, New York. Information: Ann J. Boehme, associate director for continuing education, Long Island Medical Center, New Hyde Park, NY 11042.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Nov 3-6, Dallas, Texas. Information: Judith Evans, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

American Association for Advancement of Behavior Therapy Annual Meeting — Nov 13-16, Chicago, Illinois. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

14th Annual Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Nov 17-21, Boston, Massachusetts. Information: Kristine Niven, administrative associate, Center for the Study of Drug Development, Tufts University, 136 Harrison Ave, Boston, MA 02111.

SECAD XI: Southeastern Conference on Alcohol and Drug Abuse — Dec 3-7, Atlanta, Georgia. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, 11050 Crabapple Rd, Ste D-120, Roswell, GA 30075.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, 1987, Orlando, Florida. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Alcohol Problems in the Workplace: Beyond Employee Assistance — June, 1987, La Jolla, California. Information: Tom Colthurst, Program on Alcohol Issues, University of California, San Diego, X-001, La Jolla, CA 92093.

Abroad

Psychiatry and its Related Disciplines: The Next 25 Years — Aug 12-22, Copenhagen, Denmark. Information: DIS Congress Service, Linde Allé 48, DK-2720 Vanlose/Copenhagen.

14th International Cancer Congress — Aug 21-27, Budapest, Hungary. Information: Crimson Travel Service, 39 John F. Kennedy St, Cambridge, Massachusetts 02138.

International Commission for the Prevention of Alcoholism and Drug Dependency 6th World Prevention Congress — Aug 31-Sept 4, Nice, France. Information: ICPA executive director, 6830 Laurel St NW, Washington, DC 20012.

10th World Conference of Therapeutic Communities — Sept 7-12, Eskilstuna, Sweden. Information: The United Swedish Foundations, Box 354, S-641, 23 Katrineholm, Sweden.

10th International Conference on Alcohol, Drugs, and Traffic Safety — Sept 9-12, Amsterdam, The Netherlands. Information: Symposium secretariat, QLT, convention services, Keizersgraacht 792, NL-1017 EC Amsterdam.

International Symposium on Young Drivers' Alcohol- and Drug-Impairment: Selective Countermeasure Program Development — Sept 13-15, Amsterdam, The Netherlands. Information: International Drivers' Behaviour Research Association, 34 ter rue de Longchamp, 92200 Neuilly, France.

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, dept of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

World Conference on Addiction — Oct 19-25, Vienna, Austria. Information: Barbara Turner, conference coordinator, Bldg D, Ste 120, 11050 Crabapple Rd, Roswell, Georgia 30075.

Alcohol Problems in Celtic Countries — Oct 30-Nov 2, St Peter Port, Guernsey, Channel Islands. Information: P.J. Lemmon, Guernsey Council on Alcoholism, 50 The Bordage, St Peter Port, Guernsey, Channel Islands.

Society for Prevention of Drug Abuse 1st Scientific Congress: Problems of Drug Addiction —Nov 3-4, Warsaw, Poland. Information: Congress organization committee, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warszawa, Poland.

11th World Congress for Social Psychiatry — Nov 6-11, Rio de Janeiro, Brazil. Information: J. Alberto Costa e Silva, Faculdado de Ceincias Médicas, Hospital de Clinicas, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil.

International Federation of Non-Governmental Organizations for the Prevention of Drug and Substance Abuse 8th Annual Conference —Dec 13-19, Sydney, Australia. Information: Chairman, program committee, PO Box 477, Canberra City ACT 2601, Australia.

7th International Conference on Alcohol Problems — April 5-10, 1987, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 388; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $24 per year
Air Mail: add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

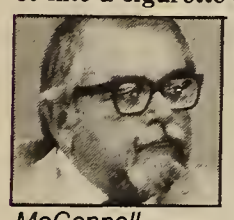
Siegel urges more vigorous education programs

Coca paste — an ominous successor to crack?

LOS ANGELES — Coca paste smoking could rapidly replace "rock" and "crack" use in the United States, especially among inner city youths, if it becomes widely available. A spectre of what is happening today in South America haunts US experts familiar with the spectacular rise of cocaine production there: untold numbers of young people punished not only by cocaine, but also by the kerosene, gasoline, and sulfuric acid residues in the coca paste, which they mix with tobacco or marijuana and smoke.

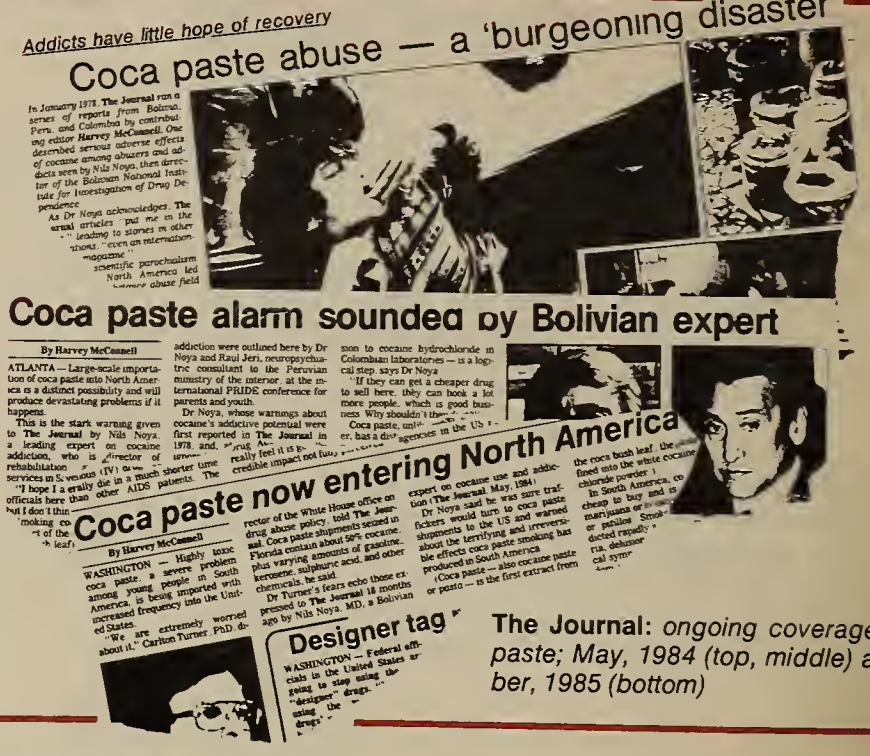
One of the experts is Ronald Siegel, PhD, a psychopharmacologist at the University of California, Los Angeles (UCLA). An expert on cocaine addiction and treatment, he is currently engaged in a research program on coca paste smoking in Ecuador and establishment of the South America's first institute on drug problems.

Dr Siegel's fear is that coca paste may become even cheaper than rock or crack, and abusers could find it more appealing because it only needs to be rolled with tobacco into a cigarette and smoked to obtain the same effects as crack. (See page 1.) He says if coca paste does become widely available, "It would cause more problems than all the other problems with cocaine put together. It would be accessible to everybody. Money would not be a problem any more in affording cocaine."



McConnell

In a conversation with Washington contributing editor Harvey McConnell, Dr Siegel talks about the problems widespread coca paste use might create in the US, possible ways to stave off the threat, and his hopes for the future in the southern hemisphere.



Addicts have little hope of recovery

Coca paste abuse — a 'burgeoning disaster'

In January 1978, The Journal ran a series of reports from Bolivia, Peru, and Colombia by contributing editor Harvey McConnell. One described serious adverse effects of cocaine among abusers and addicts seen by Nils Noya, then director of the Bolivian National Institute for Investigation of Drug Dependence.

As Dr Noya acknowledges, The ... articles ... led me in the ... leading to stories in other ... even an internation... magazine ... scientific parochialism ... North America led ... abuse field ...

Coca paste alarm sounded by Bolivian expert

By Harvey McConnell

ATLANTA — Large-scale importation of coca paste into North America is a distinct possibility and will produce devastating problems if it happens.

This is the stark warning given to The Journal by Nils Noya, a leading expert on cocaine addiction, who is director of rehabilitation ... services in S. ... (IV) ... officials here than ... but I don't thin... moking co... t of the ... h leaf.

addiction were outlined here by Dr Noya and Raul Jeri, neuropsychiatric consultant to the Peruvian ministry of the interior, at the international PRIDE conference for parents and youth.

Dr Noya, whose warnings about cocaine's addictive potential were first reported in The Journal in 1978, and, ... really feel it is g... credible impact not ...

sion to cocaine hydrochloride in Colombian laboratories — is a logical step, says Dr Noya.

"If they can get a cheaper drug to sell here, they can hook a lot more people, which is good business. Why shouldn't they ...

Coca paste, unl... er, has a dis... agencies in the US ...

Coca paste now entering North America

By Harvey McConnell

WASHINGTON — Highly toxic coca paste, a severe problem among young people in South America, is being imported with increased frequency into the United States.

"We are extremely worried about it," Carlton Turner, PhD, director of the White House office on drug abuse policy told The Journal. Coca paste shipments seized in Florida contain about 50% cocaine, plus varying amounts of gasoline, kerosene, sulphuric acid, and other chemicals, he said.

Dr Turner's fears echo those expressed to The Journal 18 months ago by Nils Noya, MD, a Bolivian expert on cocaine use and addiction (The Journal, May, 1984).

Dr Noya said he was sure traffickers would turn to coca paste shipments to the US and warned about the terrifying and irreversible effects coca paste smoking has produced in South America.

(Coca paste — also cocaine paste or pasta — is the first extract from the coca bush leaf. The ... fined into the white cocaine ... chloride powder.)

In South America, co... cheap to buy and is ... marijuana or ... or pitillos. Smok... dicted rapidly ... nia, delusion... cal symp...

Designer tag ...

WASHINGTON — Federal officials in the United States ... going to step using the "designer" drugs. ... using the ... drugs" ...

The Journal: *ongoing coverage of coca paste; May, 1984 (top, middle) and October, 1985 (bottom)*

Haunting similarities between as yet small-scale, coca paste smoking in the United States and the infancy of cocaine freebasing in the early 1970s are worrying Ronald Siegel.

Dr Siegel has for years done research into a myriad of psychoactive drugs: mescaline, peyote, LSD, amphetamines, PCP, cocaine, and even MDMA (**The Journal**, July). He treats, as well, people addicted to psychoactive drugs, especially cocaine. Currently, he is taking a year off from the department of psychiatry and behavioral sciences at the University of California, Los Angeles, (UCLA) to write a book. He travels extensively in Latin America, including a recent helicopter trip with Ecuadorean troops on an eradication sweep.

He is caught between fears coca paste smoking will replace the present penchant for rock or crack, with even more devastating results, and that widespread publicity could propel many people to try it.

Siegel: users seduced

Says Dr Siegel: "People close to the trafficking circles are the ones we have picked up and the ones who are using coca paste. They are part of the community: users, traffickers, distributors, importers.

"This is exactly how cocaine freebasing started in California in 1970; it was then a small, isolated, regional problem."

In 1970, he agreed with officials at the US National Institute on Drug Abuse that freebasing could turn out to be a small scale Californian phenomenon, that there would be no publicity about it, and that he would keep an eye on the situation.

Dr Siegel found this suited the cocaine freebasers of the day to a tee.

"The people we contacted in 1970 who were freebasing would tell us, 'It's too nice. Don't talk about it. Don't let people know. We're telling the dealers about it because they are the only ones who can afford it. It's a mother.' They were afraid of it, and they were ecstatic about it."

Users seduced

Then, entertainer Richard Pryor nearly killed himself. "And, we decided once the cat was out of the bag, once freebasing started to get publicity, we would write a clinical note to the *New England Journal of Medicine*, which I did.

"A lot of people hearing about freebasing wanted to know about it and to try it. The first experience is euphoric for many people and that seduced a lot more users.

"On the other hand, you always have that: publicity about a new drug initially increases experimentation. The same thing happened recently with MDMA ('ecstasy')."

Freebasing became more popular, the price of cocaine dropped, and the numbers of users kept increasing.

But, today, those who freebase represent a shift in the economic hierarchy.

"We are no longer seeing a lot of celebrity and high socio-economic class users: we are seeing a lot more users, but in lower socio-economic classes," Dr Siegel says.

Inner city kids

That is the rub: coca paste, or cocaine sulfate, is the first extraction from the coca leaves. It is refined into cocaine hydrochloride, the white powder snorted or injected, and into cocaine freebase, which is smoked.

Dr Siegel says his fear is that if coca paste is sold cheaply, "it could become very popular, particularly among the inner city youths in the US who are gravitating toward cheap amounts of rock and crack freebase, in individual doses.

"In Los Angeles, we have a lot of black and Hispanic groups who like cocaine and have never been able to afford it in the amounts necessary to smoke it. But now, they can afford little $10 to $25 rocks.

"Coca paste could be even cheaper. And you can smoke coca paste as it is. You can put it into a tobacco cigarette. You don't even need a pipe, you don't need a torch, you don't even need to have it manufactured as 'rock houses' do. You eliminate the whole middle part of the chain."

In the past two years, Dr Siegel has studied 45 coca paste smokers in California, Arizona and Florida. All are close to the trafficking gangs.

The users found coca paste appealing for several reasons. "The first is that it is convenient to use. Secondly, they liked the rush. They said it was like cocaine freebasing, but without the hassle. Thirdly, it had the same effect as freebasing.

"We have found that the data on coca paste smokers collected in Peru by Raul Jeri (MD, chairman of the drug addiction committee of Peru's Ministry of the Interior) are almost identical in terms of psychopathology and the physical effects we saw with freebasers."

Dr Siegel thinks another reason coca paste smoking is so worrisome is its dirtier preparation. "The kerosene, methanol, and sulfuric acid present health hazards that we haven't even begun to assess."

Dr Siegel suggests that, ironically, one of the ways coca paste smoking could spread in the US is through heightened law enforcement efforts.

"Laboratories for processing cocaine are moving into south Florida, and perhaps elsewhere in the United States. They are working with coca paste, refining it into cocaine hydrochloride. As they get busted — and they are — this leaves a lot of unrefined coca paste around."

Another way for coca paste use to spread is by people trying to minimize their risk of arrest by distributing paste-like samples to test if there is a market.

In the long-term, there will probably be some homegrown coca paste around. "If we have domestic coca production, we are going to have domestic coca paste," Dr Siegel says. "We know we have domestic coca production, but it is window box stuff, novelty growing, private, backyard greenhouses. It is not commercial as far as we know, but it could be so easily."

Scarface image

Because there is a lag time of at least two years before coca bushes mature, Dr Siegel says, there is time to stop the problem. He says the dangers call for tough approaches and educational programs.

"One approach is to emphasize the dirty nature of the coca paste, how problematic it is, the pulmonary dysfunction we see in cocaine freebasers, and the reports we have from Peru that this dysfunction is even more exaggerated by coca paste.

"I think we need to emphasize the 'Scarface' image of cocaine trafficking, and that cocaine is . . . not as glamorous and glittering and socially acceptable as Burt Lancaster made it seem when he pedalled it in *Atlantic City*.

"And, we need to emphasize that cocaine is becoming a drug associated with narco-terrorism and a lot of criminality throughout the world, that users who continue to use cocaine in any form are participating in the growth of international terrorism.

"If these messages are driven home, and as the kids go more and more into the inner cities to find this stuff, they will find they are getting more and more of a junkie image. I think that is good. I think that is one of the things that has helped check heroin a little bit: the image of being on skid row, a junkie with a needle in your arm."

Enforcement needed

If inner cities are the main source of coca paste and other forms of cocaine, then educational and law enforcement efforts need to be vigorously increased.

Dr Siegel draws an analogy about law enforcement efforts against PCP in recent years and similar efforts which should be made now against cocaine.

"The PCP problem was exactly centred in the inner cities. The educational messages didn't mean anything. But, what did help was successful law enforcement in cracking down on the labs.

"If coca paste follows the same patterns, we are going to have to have effective law enforcement in cracking down on domestic distribution. Then, the toxicity of coca paste and other forms of cocaine could turn off the rest.

"I am not saying coca paste has PCP-like effects. They differ. Yet, when you look at the coca paste users in the slums of South America, as I have, you get *déjà vu* that you are walking through the barrios of Los Angeles where PCP is being used. The users look the same."

The plight of people in South America is one reason Dr Siegel is becoming involved in the formation of the Latin American Scientific Institute on Drug Studies, which will be part of the Andean nations university to be constructed at Sucre, Bolivia.

"A lot of the wealthy South Americans with drug problems are sent to Miami clinics and hospitals. For the inner city kids who are most affected, there is no treatment, no help. Nothing is being done.

"That is one of the things that this new institute can try to organize. At least, they are motivated at very high levels to do something about their problems.

"They are still mad at us for starting the whole thing with our insatiable demand for drugs. But, they are recognizing that they have problems too and they have got to start addressing them."

At present, the institute exists only on paper. Dr Siegel has been asked to take part in the planning and its establishment: he is exploring the possibility of a formal link between the institute and UCLA.

The institute's goals are to provide epidemiological and demographic information in the regions. "We have virtually nothing. The few studies done have been in the major cities, and it is not enough."

Drug peace corps

There is a crying need to consolidate training for treatment, rehabilitation, and preventive efforts.

Dr Siegel: "In a country like Ecuador, there is only one cocaine treatment facility for the entire country. I think there is only one drug abuse treatment facility in the entire country."

Dr Siegel suggests one of the best ways to tackle the South American situation is "some kind of program in North America where we send down fellows for two years at a time, sort of a drug peace corps.

"Bringing people here (US) doesn't help: the problems here and the institutional arrangements are so different."

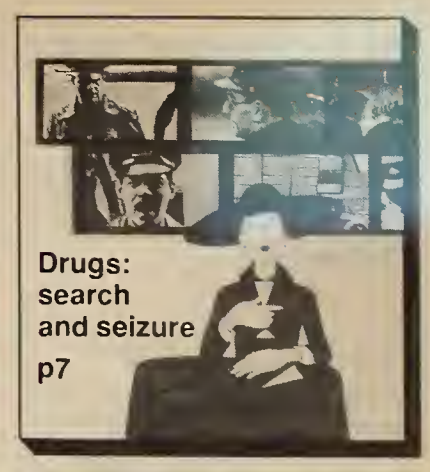
The *quid pro quo* is, he hopes, a number of research opportunities in the land where it all starts. Already, he has begun a study of diagnosis and evaluation of coca paste users and patterns of use and demographies in the city of Guayaquil, Ecuador.

THE BACK PAGE

Vol. 15 No. 9 2nd Class Mail Reg No. 2776 TORONTO, September 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems



Euro-MP urges continental strategy

Europe's anti-drug efforts called 'laughable'

By Harvey McConnell

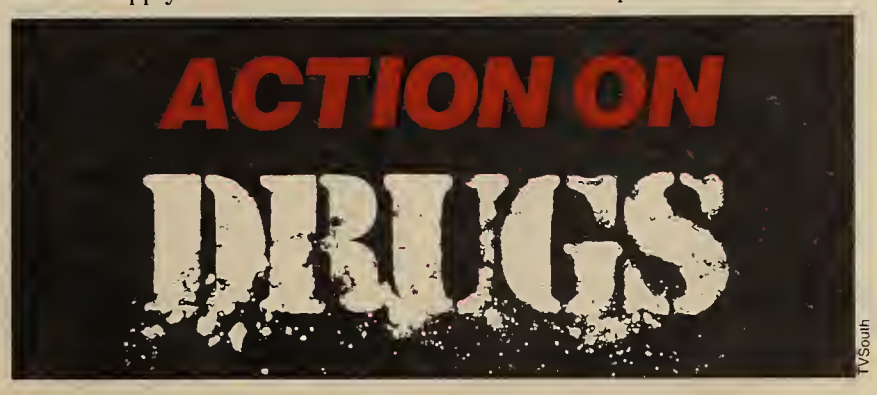
BRIGHTON, England — Heroin addicts number in the millions and a cocaine tide is sweeping across the Atlantic, but any idea of coordinated West European efforts is laughable, says a British member of the European Parliament.

Banks, chemical companies, police, customs, laws, judges, churches, and local communities took a hammering from Sir Jack Stewart-Clark, who galvanized the European Parliament in Brussels to set up a year-long investigation of drug abuse. A report will be released in October.

In a flying visit to a conference held here by the regional commercial television company, Television South, which is producing 10 hours of Action on Drugs programming, Sir Jack displayed a depth of knowledge about drug information from North America and the rest of the world rare in a leading European politician.

He told the diversified audience, ranging from psychiatrists to customs officials: "I don't think we realize the extent of this problem — not even those in this room, and certainly not those generally in the country.

"We have to deal with every link in the chain on the demand side and the supply side."



Sir Jack, who recently conferred with top Reagan administration officials in Washington, continued: "I have to tell you that coordination of activities between customs and police even in this country is laughable, and, if you look at it on a European Community basis, it is even more so.

"I sometimes think we don't know what the word cooperation really means. And, have we learned from past mistakes: what Holland and Spain did with over-permissiveness, what the United States has done by throwing money at the problem?"

There can be no compromise: "We have got to get a European strategy as well as a national strategy. If we don't have a European strategy, and we can't look across other people's borders and try to get our act together, then I am certain we are going to lose this war."

Although drug-user statistics are non-existent in some countries, or are calculated in different ways, he said: "I reckon that in the 12 nation states of the European Community today there are between 1,500,000 and 2,000,000 regular heroin users, all between the ages of 17 and 25."

While the US can put a price tag on what drug abuse costs the nation, "we don't know what it costs in Europe. Nobody has the figures."

Prevention tack is critical, says UK drug chief p11

He warned that Europeans must not be preoccupied with heroin to the exclusion of other drugs, particularly cocaine. "There is every single sign there is too much cocaine in the US today and that it is on its way to Europe" (**The Journal**, July, 1985).

In 1985, for example, West German authorities seized more cocaine than heroin.

West European efforts, coordinated or otherwise, are pitiful in the area of crop substitution. He pointed out that 90% of the heroin comes from Pakistan, Afghanistan, Thailand, Laos, and Burma, and 90% of the cocaine from Peru, Bolivia, and Colombia, all poor developing countries.

"But, at the end of the day, how

(See Bank, p2)

Reagan shifts US drug focus to prevention

By Harvey McConnell

WASHINGTON — Substance abuse prevention has taken centre stage here, from the White House, to Capital Hill, through the media, to the grassroots.

'Crack' deaths of sports stars Len Bias and Don Rogers, President Ronald Reagan's call for wider drug testing, coupled with treatment, and enormous pressure on the United States Congress in an election year have put new vigor into Mr Reagan's war on drugs (**The Journal**, May).

The First National Conference on Alcohol and Drug Abuse Prevention held here by the US National Institute on Alcohol Abuse and Alcoholism and the US National Institute on Drug Abuse had double the attendance expected, plus an unscheduled speech by Mr Reagan.

The president told the conference: "We are against the use, not the user. We are talking about the pressure the rest of us, who care, can put on the user to mend his or her ways."

In the early years of the Reagan administration, the focus was on interdiction and eradication: hitting the growers, the transporters, and the sellers. There has been some success, and the pressure will continue.

"But, what we've launched in the last few days has been an offensive against demand," Mr Reagan said. "This, in the long run, is the answer. Let's take the customers away from the drug peddlers."

It is clear US domestic demand for drugs fuels international drug trafficking "and cuts at the social, political, and economic fabric of friendly countries."

Mr Reagan is calling back to Washington, for special consultation, ambassadors from countries which may face major drug production, transportation, or consumption problems. The ambassadors will return to their posts with the message that the US emphasis now is on cutting back domestic demand for drugs.

Mr Reagan said his six goals are: drug-free workplaces, drug-free schools, more-effective prevention and treatment through research, international commitment to defeat drug trafficking, strengthened law enforcement, and, most important of all, "increased public awareness and involvement in the fight against drugs."

He added: "We must make drug use the top item in the national dialogue, so that every citizen realizes what the stakes are, for the individual and for the country."

Earlier, Ian Macdonald, MD, administrator of the US Alcohol, Drug Abuse and Mental Health Administration, told the conference: "Prevention is now in, and appropriately so."

The conference itself was an indicator: the 750 registration limit was passed weeks earlier, and the final total was 950 attendees.

Dr Macdonald pointed out some research can meet very exacting scientific criteria, whereas in prevention, "we all know it works, but it is harder to prove."

Some changes can be proven in awareness, attitudes, and availability. This is reflected in the drop in marijuana use by US high school seniors (**The Journal**, December, 1985), and the drop in overall hard liquor consumption in the US in recent years.

The deaths of Mr Bias and Mr Rogers certainly demonstrated how awareness can be heightened, he said. A press conference held by the US Department of Health and Human Services (DHHS) following the Rogers death was one of the best attended at the department.

Dr Macdonald explained the focus was on the effect of cocaine on the heart (**The Journal**, July): "I was stunned by a question from a reporter from one of the major, national newspapers, who said, 'How come you didn't tell us before that cocaine could kill you by its effect on the heart?'

"And, of course, the answer was that the reporter really hadn't been listening; we have been saying so for years. But, the media is now with us and that is a tremendous change."

Dr Macdonald said signs indicate that an office on prevention, authorized by the US Congress, will be established in his office.

Otis Bowen, MD, DHHS secretary, told the prevention confer-

(See Reagan, p2)


Reagan: use is 'out'


Macdonald: prevention 'in'


Hollobon: all medical writers

Canadian physicians honor TJ writer for educating public

WINNIPEG — Joan Hollobon, Contributing Editor (Toronto) of **The Journal**, has been awarded the Canadian Medical Association (CMA) medal of honor for her contribution, as a medical writer for more than 25 years, to public education.

The medal, instituted in 1982, is the highest award the CMA can bestow on non-physicians for personal contributions to medical research, medical education, or health education.

Ms Hollobon is the second journalist to receive the medal: Vancouver geneticist David Suzuki, PhD, was the 1984 recipient for his work in popularizing science and medicine on radio and television.

This year's citation states that "medical reporting is an art and a science (that) requires raw talent and polished skill," and Ms Hollobon "is its acknowledged master."

A native of the Isle of Wight, she came to Canada in 1952 and joined the *Globe and Mail* in 1956, after working on newspapers in Kirkland Lake and North Bay.

Ms Hollobon began medical reporting in 1959, continuing until her retirement from the *Globe and Mail* in 1985. She became a contributing editor of **The Journal** that year and also continues as a freelance medical writer.

The CMA medal isn't her first recognition by the medical profession. In 1974, she was made a fellow of the Toronto Academy of Medicine and, in 1985, an honorary member of the Ontario Medical Association (**The Journal**, October, 1985).

In accepting the medal at the CMA annual meeting, Ms Hollobon said she regards it as recognition by physicians that "talking to the public is worthwhile." She accepted the award not so much as a personal one, but as one honoring all Canadian medical writers, particularly pioneers Ken McTaggert, David Spurgeon, Fred Poland, and Herb Lampert.

INSIDE

NEWS

Briefly ...

It's in the mail

MONTREAL — The Canadian postal system is now the best way to import drugs into the country, says the French-language private television network *Tele-Metropole* here. Last year, customs inspectors seized $235 million worth of narcotics headed for distribution through the post office, the network says through a *Canadian Press* story.

A farewell to ale

LONDON — British beer-drinking fashions are changing with pub devotees turning their noses up at the traditional drink of ale in favor of lager. *Reuter* says for disciples of ale the trend toward lager is like the abandonment of the British Empire. Although flat, dark, warmish ale has long been the staple of most pubs, Britons now thirst for lighter — and gasier — lager.

Virtue needed

SANTA SPIRITUS, Cuba — The United States has a drug problem because its people don't know how to "practise virtue," Cuban President Fidel Castro says. In a speech marking the 33rd anniversary of his first guerilla raid, *The Toronto Star* reports, he denounced US military anti-drug offensives in South America. Cuba has no drug problem, the president boasted.

Crop shopping

SIMCOE, Ontario — The Ontario government will spend $930,000 during the next three years helping tobacco farmers find alternate crops to plant. Agriculture Minister Jack Riddell said here the new crops will have to be competitive internationally, *The Toronto Star* states.

End in sight

VIENNA — Burma has reduced its production of illicit opium by 50% in the last 10 years, thanks to assistance from the United Nations Fund for Drug Abuse Control (UNFDAC). Contributions from Norway, recently increased by $8.5 million, are aimed at ending illicit opium production in Burma by 1991, the *UN Information Service* says.

Alcoholic trees

JERUSALEM — Hebrew University scientists here report a cure for fruit trees that produce alcohol in their roots during winter floods. Professor Arye Gur imitated the natural processes of more resistant trees by using chemical growth regulators and enzyme inhibitors to block alcohol formation. The alcohol was ruining fruit crops and damaging trees.

One more out

OTTAWA — One of the few street-synthesized ("designer") drugs found in Canada, MEM (4-ethoxy-2, 5-dimethoxyamphetamine) has been outlawed by order of the Canadian Cabinet. MEM is an hallucinogenic drug 20 times more powerful than mescaline, *The Globe and Mail* reports, and was first seized during a narcotic raid here in May.

Continuum of treatment should match problems

Intense alcohol care often unneeded

By Joan Hollobon

TORONTO — The growth of expensive alcoholism treatment services into a multi-million dollar industry in the United States hinders development of briefer, cheaper, and, for many people, more effective forms of care, an Addiction Research Foundation (ARF) scientist here says.

Martha Sanchez-Craig, PhD, suggests that a continuum of care should exist to match the continuum, from mild to severe, of people with drinking problems.

In an editorial in the October issue of the *British Journal of Addictions*, Dr Sanchez-Craig, an ARF behaviorial research psychologist, urges the development of brief, outpatient programs, at reasonable cost, which have: flexible goals ranging from abstinence to "limited non-problem drinking," flexible treatment schedules to avoid disrupting the individual's work or domestic activities, and a treatment model that agrees with the person's own view of the problem.

Despite the "apparently innocuous conclusion" proclaimed years ago by authorities in Britain and the US that "a variety of treatments with a broad range of intensities should be available to deal with the broad range of client problems," most programs still offer a "single approach with astonishingly little variation in the intensity of treatment offered," Dr Sanchez-Craig writes.

Typically, this "average package of care" consists of one month of inpatient treatment followed by one or two years of weekly aftercare.

This intensive package may be necessary for severe chronic alcoholics, Dr Sanchez-Craig told The Journal. But, directing almost all resources toward this minority ignores the opportunity for early intervention, before jobs and families are disrupted, among the vastly greater numbers of moderate problem drinkers.

Statistics show that in the Ontario general population, there are 20% problem drinkers, but only 5% alcoholics; 60% are social drinkers, and 15% abstainers.

Also, the "one package" approach deters those who do not

Sanchez-Craig: flexible goals

consider themselves yet alcoholic and who fear being labelled, embarrassed, and possibly risking their jobs.

Reluctance to seek treatment is usually viewed as denial, causing health care workers to clamor for better methods of identifying the "deniers."

But, Dr Sanchez-Craig contends that people with less severe problems often are denying only the appropriateness, for them, of available services. She believes many will voluntarily seek help if services appeal to them.

Her research supports her view: a newspaper advertisement offering brief, confidential, outpatient treatment, with flexible hours, aimed at achieving a reduction in drinking had her telephone ringing off the wall.

"There were 60 calls in one day: I was going mad with the telephone."

Treatment limited to two or five sessions must be extremely skillful.

Confidentiality is essential: many people will only attend if they can prevent their employers or their families from finding out, Dr Sanchez-Craig said.

"The first thing I tell them is, 'This option (moderate non-problem drinking) is not easy, abstention will be easier; you make the decision and you don't have to think about it, you have to work hard at it. . . . If you are not willing to invest the time and energy, I would not recommend it for you.' "

Reagan wants federal employees tested

(from page 1)

ence that while "children growing up today face very dangerous choices," he thinks there is "now a strong consensus across the land that alcohol and drug abuse are wrong and that people who use them must be held accountable for their actions."

He said Mr Reagan realizes recent drug raids in Bolivia involving US armed forces were only a signal: "The way to shut off the supply is to shut down the demand."

Michael Dukakis, governor of Massachusetts, said in the last two years his state has launched an effective demand reduction program, Alliance Against Drugs.

Mr Dukakis said an investment of even a fraction of the money now being spent on the 'Star Wars' defence program, "in a national alliance against drugs, may be of far more importance in the future."

Meanwhile, Mr Reagan, Vice-President George Bush, and 78 presidential assistants underwent drug tests, and the US Department of Defense considered moves to have contractors establish programs to combat drug abuse among workers. Officials said they have a right to know the equipment on which lives depend is made in a drug-free atmosphere.

Mr Reagan wants urine testing of all federal employees holding sensitive posts in law enforcement, national security, safety, and public health fields.

A five-month study by a US House of Representatives subcommittee declared many urinalysis tests are inaccurate and some drug testing laboratories do sloppy procedures, with a 5% to 25% rate of false-positive results.

The report said unannounced testing can "effectively scare employees away from using drugs," but it can also be demoralizing and affect productivity.

In a renewed media focus on drugs, a bipartisan group of 338 members of the House called on the major US television networks to launch an advertising campaign against illicit drug use.

A number of bills will also come before the US Congress soon.

One house member was candid: members on both sides of the chamber are being pushed by constitutents to do more against drugs. In November, all members of the House and one third of US senators are up for re-election.

Canadian prevention plan awaiting Cabinet approval

OTTAWA — Details of a Canadian government anti-drug campaign, now being reviewed by Cabinet, should be made public this fall.

The program is expected to concentrate on preventive education in Canadian schools and workplaces.

A spokesman in Health Minister Jake Epp's ofice told The Journal details of the prevention plan cannot be discussed until Cabinet approval is given. Information should be available later this fall, Marc Allard said.

In August, *The Toronto Star* quoted Mr Epp as saying Canadians "need a thrust that is innovative and that won't be a flash in the pan." Mr Epp said the Canadian campaign will emphasize education and interception, instead of concentrating on mandatory drug testing, an integral part of United States President Ronald Reagan's war on drugs (see page 1).

Bank, customs rules part of problem

(from page 1)

many are there? I can count them and you can count them on the fingers of your hands. Yet, it seems to be beyond the powers of the entire Western world to do anything about it."

The United Nations Fund for Drug Abuse Control gets $20 million a year, while earnings by traffickers world wide is about $300 billion.

Sir Jack blasted West European chemical giants and the rest of industry.

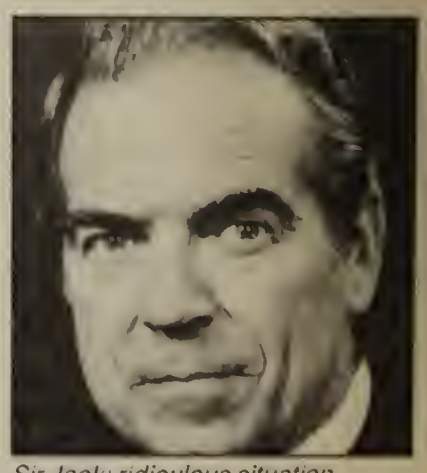
"We are not blameless ourselves. We have the chemical industry in West Germany and other parts of Europe quite merrily exporting chemicals which are being used for the wrong purposes."

He was equally scathing about European banking institutions and their obsession with secrecy. Traffickers keep closer to their money than their drugs, "yet we have the ridiculous situation of many banks in many countries, where secrecy is such they are not allowed to say they have large scale, continuous cash deposits quite clearly coming from drug sources."

The law is in a similar mess. Traffickers can get up to life in Britain, but only 12 years maximum often commuted to six years in Spain. Judges are equally quixotic in sentencing in Britain as in the rest of Europe.

The biggest stumbling blocks to international cooperation are police and customs services. Even an exchange of information is often blocked.

Sir Jack: "I was shown by British customs just two weeks ago a wonderful computer system which they call CEDRIC. And, CEDRIC is very good because it enables the British customs to gain intelligence about traffickers and those who are plying the drug trade.



Sir Jack: ridiculous situation

"The only problem is that CEDRIC is not compatible with any other computer system operated by any other customs force in Europe.

"Until the countries of Europe, including Britain, recognize that something isn't just within our own borders, we are not really going to be able to lick the problem."

NEWS

Use patterns indicate treatment needs of young

By Betty Lou Lee

HAMILTON — Not all adolescents using alcohol or other drugs have drug dependency problems, but parents and peers tend to think in "all or none" terms, says Dick O'Brien, a human relations consultant in Burlington, Ontario.

Parents think of the child as being "on drugs," and schoolmates divide students into "users and non-users."

Describing five patterns of use, from nil to initial, recreational, daily, and chronic, Mr O'Brien said the initial and recreational users have adolescent problems relating to others and feeling at ease. This is the group open to counselling, information, and awareness programs.

The daily user has "one foot in a normal and the other in a drug lifestyle." He or she is still in school and at home, but is "self-medicating and filled with self-deception.

"For the daily user, it is the most important thing in life. For the chronic user, it's the only thing in life."

The chronic don't respond to individual counselling and require "severe intervention" like a residential program, he said.

Mr O'Brien has worked out a four-factor, predictive model that includes the benefits and consequences of drug use and the benefits and consequences of being drug-free.

If the perceived benefits of use and the consequences of being drug-free outweigh the other two, use will continue. But, if the young consider the benefits of being drug-free and the consequences of use outweigh the other two, "they will start to move toward being drug-free."

Most young daily and chronic users block out the consequences of use, he said, and the chronic see no benefits of being drug-free. "They could care less about parents, cops, school, or money. They're socially and emotionally bankrupt."

O'Brien: self-deception

But, they can see consequences of being drug-free: being friendless because using-friends will be threatened and others know them as "dopers." They don't know how to cope, how to say no, or how to get money (if they've been dealing). Adults who have labelled them will be suspicious.

Mr O'Brien said one aim of a counsellor should be to get users to see specific alternatives: lists of friends and places to avoid, role playing to learn how to say no, awareness of making choices, and being responsible for them.

Speaking at the 27th annual Institute on Addiction Studies held at McMaster University here by Alcohol and Drug Concerns Inc, he cautioned counsellors against using street talk.

"It gives credibility to the drug-using lifestyle, and you look foolish and totally out of place."

Addicts relapse under usual regimes

Cocaine patients need different program: Dowsling

By Betty Lou Lee

HAMILTON — New treatment programs specific to cocaine are needed because those geared to alcohol and other drugs aren't working, says a Toronto physician who has specialized in addictions for 10 years.

"It is not just another drug," Janet Dowsling, MD, told **The Journal** at the 27th annual Institute on Addiction Studies held here by Alcohol and Drug Concerns Inc.

"It's an extremely addictive drug, powerful, magnetic, seductive. Addicts come into programs, but they relapse as soon as they leave . . . . Cocaine hooks into the ego and self-confidence more than other drugs, and anything that makes you feel good is hard to give up."

Dr Dowsling, former coordinator of medical services at the Donwood Institute, is now medical consultant with Bellwood Health Services and the Jean Tweed Centre for Women in Toronto.

Dowsling: magnetic

"It (cocaine) is the most scary drug I've seen, and our treatment approaches are not dealing with the problem. I don't know the answer.

"The psychology involved is different . . . . It affects the sense of self-confidence in a much different way. You don't take a Valium (diazepam) and feel like Superman."

Dr Dowsling suggests that some control over the addict's money may be an important aspect of rehabilitation.

"For a recovering addict to walk around with $200 in his pocket is crazy. It's like an alcoholic walking around with a mickey. The allure is irresistible."

Fehr: profound craving

Another speaker at the institute, Kevin Fehr, PhD, a scientist at the Addiction Research Foundation, Toronto, also referred to the addictive properties of cocaine: "It produces the most profound craving that's been seen."

She outlined a rat study in which one group was allowed all the heroin it wanted for a month, another group all the cocaine. At the end of the month, 30% of the heroin rats were dead, 90% of the cocaine. While the heroin rats took about the same amount of their drug each day, the cocaine rats went on "binges and crashes," wouldn't eat, and went into seizures.

Dr Fehr said a number of treatment programs are looking at this craving and compulsion.

She said 'crack,' a form of freebase cocaine (**The Journal**, August), is neither a new drug nor a cheap one.

While two small chunks may be bought for $20 to $30, which is cheap per unit dose, it can still add up to $200 to $300 a night.

Unlike the original cocaine freebase that surfaced in California in the late 1970s, crack doesn't require the chemical sophistication involved with ether extraction.

"It's like fast food: you don't need the equipment or the know-how."

New Zealand uses computers to identify worst drug abusers

AUCKLAND, NZ — New Zealand's worst prescription drug abusers have been placed on a computer listing to enable doctors and chemists to identify them.

The Health Department has placed restriction orders on 414 people known for their constant abuse of drugs like morphine, pethidine (eg, Demerol), and barbiturates.

Names. aliases, addresses, and physical descriptions are listed. Doctors can check the list by telephone.

The department says the listing has become necessary because of the number of physical attacks and threats to the lives of doctors, chemists, and their families, by addicts.

INSIDE OUT

Reflections on a mother's life

I knew as soon as I turned the corner at the intersection and saw the police cruiser, then the ambulance, and finally the small woman waiting unsteadily at the front entrance of the apartment building in a fine area of the city.

I knew as soon as the small, fearful woman saw me standing there before her, in the foyer, that she'd start to shake a little. And, she did.

And, I knew when I told her I was there to see my mother, who'd been living in the building for a couple of months after coming back home from another city and another era, that the small, still-unsteady woman was then going to say: "Something has happened."

But I went on anyway, knowing of course — I was seeing everything with a clairvoyant brilliance — what the small, now infinitely compassionate woman was going to reply when I asked: "Is my mother dead?"

The woman, who was the superintendent, I knew, although I'd never met her before, and with whom I now felt bonded forever, nodded, and shook slightly, again.

Maybe that small, kind woman was amazed, as I think back on it now, at how poised I must have seemed then, as we stood near the mailboxes by the sofa in the foyer, on a sunny, summer morning.

But, I had known when I first saw my mother after she'd arrived here, following her move from that other city that had always fuelled so many mixed and repressed emotions in her, that something was wrong. Her energy was diminished, she repeated herself, she looked pained, she was withdrawn. She was just going through the motions.

She had come home, knowing it not in her consciousness but in the subtle, increasingly more urgent messages her body whispered to her, to get ready to die.

We had had a cigarette in her new living room, and I had gone through my own motions: keeping the talk banal, obvious, always taking pains never to enter any serious waters. We had never shared overt emotions; ours was a relationship of classic understatement and had been for decades. We both knew the unspoken contours, the shape of what we had between us. For her, it meant keeping as many of the old, horrible doors closed as possible.

She had, instead, deserved to soar and be happy and loved . . .

What a subterranean life we had had . . . . I remember now, after I have buried her in the cemetery near my sister, a suicide years ago, that I had cried after that visit, in the elevator going back down to that same foyer, those same mailboxes, the same sofa.

My mother had never deserved what had come to her in her life. She had, instead, deserved to soar and be happy and loved; to feel permanently and easily connected to all the great, wondrous things that are right in front of us, if only we focus our attention properly.

The great tragedy for her was the relentless effect of the outside addiction that had seeped into her days like demonic sludge.

Her husband, my father, a tortured, brilliant man, was an alcoholic. His erratic, irresponsible life had ruined her younger dreams.

Her only brother, another tortured, brilliant man, was an alcoholic too.

And, so am I, her only son, although even now I wonder if she really knew how far into the disease I'd gone.

I had, I realize now, deliberately kept a distance from her, as long as I could, after I had escaped home, looking for an independence that became increasingly spurious as the years went by. I realize now I wanted to send her the message that I didn't need her anymore.

What I was really doing all along was trying to hide my own growing dependence on booze. It got so I would do and say anything to make her feel I was just fine, because the idea that she might find out that I was an alcoholic would be crushing. I knew it might be just too much for her to have to take, after what she had gone through.

But, of course, she must have known. When your life has already been shattered twice, as hers had been by my father and her brother, there can be no more *naiveté*, ever, when it happens once again.

And, of course, she must have blamed herself, wrongly, and, oh, now, now that I've not had a drink for almost two years, I wish that, earlier, much earlier, I could have done something to show her just how much I loved her, admired her. I would give anything, my soul, to have made her life fuller and charged with more hope.

But when you're drowning in a private, obsessive pool of horrors, as I was, you can't give anyone anything.

I remember our last meeting, a small family reunion. I had never felt more optimistic, I was soaring that night; she knew I had stayed sober, she knew I was making it, out there, truly on my own now, except for her. The sickness that was killing her — it was three weeks before her death — was invading her like a *blitzkrieg*. She was confused. She had looked very tired.

The last words, as we stood by the door, we ever said to each other were these:

"You know, I really love you. I want you to know that. I really, really love you."

"I know, Mom. I know it. And I really love you too."

We had kissed goodbye, that final time, and, if there's any justice at all and if we ever meet again, I'll be able to tell her, if God wills, that I spent the rest of my days here a sober man.

May she rest in peace.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Cervical cancer and smoking

A large, well-controlled, United States study has provided strong evidence of the link between cigarette smoking and invasive cervical cancer. The case-control study included 480 invasive cervical cancer patients from five US cities: Birmingham, Alabama; Chicago, Illinois; Denver, Colorado; Miami, Florida; and Philadelphia, Pennsylvania. The group was compared with a group of controls matched for age, race, and telephone exchange. The relationship of several cigarette smoking variables to cervical cancer was evaluated. While other factors were taken into account, strong evidence was found to suggest smoking is an independent risk factor for invasive squamous cell cervical cancer. Women who reported ever having regularly smoked cigarettes had a 50% elevated risk compared to non-smokers, and two-fold excess risks were seen for those smoking more than 40 cigarettes daily and those smoking for 40 or more years. Users of non-filter cigarettes were found to be at particularly high risk. However, those who had quit for at least two years had a risk comparable to that of never-smokers. The study concludes the consistency of the findings, after controlling for variables such as sexual activity, "tend to support a direct effect of smoking on the squamous epithelium of the cervix."
The Journal of the American Medical Association, June 20, 1986, v.255:3265-3269.

People more suspicious of tranquillizers

A change in popular attitudes about tranquillizers has been documented between 1970 and 1979, with United States residents becoming more suspicious of tranquillizers and their effect on health. Data were used from both the 1970 and 1979 national household surveys, conducted as part of the US National Institute of Mental Health (NIMH) research program into the medical use of psychotherapeutic drugs. Researchers from the Institute of Research in Social Behavior, Oakland, California, in conjunction with researchers from NIMH, George Washington University, Washington, and the University of Chicago, evaluated attitudes toward tranquillizers expressed by two representative groups of between 2,500 and 3,100 US adults. While both groups said tranquillizers were effective in achieving calmness and relaxation, the 1979 survey group was more concerned about presumed negative consequences of the drugs on health and behavior and in the perception that physicians overprescribe tranquillizers. Despite these negative views, people in the later poll still supported tranquillizer use to treat seriously impaired individuals. They were less supportive of using them in situations involving moderate impairment. The researchers say the survey results show the greatest change between the two polls "focuses solely on the potential risks associated with using tranquillizers. What is disconcerting is that such important changes in treatment-related attitudes came about so haphazardly, without clear reference to relevant scientific knowledge."
Archives of General Psychiatry, June, 1986, v.43:527-532.

Handicapped students' drug problems

Physically handicapped young men at a university have been found to have more problems with alcohol and other drugs than their peers. This is the finding by two San Diego physicians who evaluated 42 men, aged 21 to 25 years, with a variety of physical handicaps. The men were either students or non-academic staff at the University of California, San Diego. Drs Christiana Motet-Grigoras and Marc Schuckit administered a highly-structured, mail-in questionnaire to this group and compared the answers with a control group of 991 men, without handicaps, attending the same university. Results show the handicapped men had statistically more problems with alcohol use and reported a greater incidence of other drug use than those in the control group. "This finding alone is of clinical importance and should warn counsellors of potential problems with substance use in students having even mild handicaps," the doctors say. The study group also had a high rate of depressive symptoms and parents with alcohol and other drug problems. While the study shows these handicapped individuals may require more counselling than other students or staff, the doctors note many of the subjects may consider substance abuse problems to be a further stigma and go to great lengths to hide them.
Journal of Clinical Psychiatry, May, 1986, v.47:234-237.

Panic attacks among cocaine users

Cocaine can set off clinically significant panic attacks in previously unaffected individuals. And, these attacks can persist even when use of the drug is stopped. Two physicians from the department of psychiatry at the Health Sciences Center, State University of New York, Stony Brook, have reported on the cases of three people whose panic disorders were first precipitated by recreational use of intranasal cocaine. In each case, the patient's first panic attack occured shortly after cocaine use and returned whenever cocaine or caffeine was administered. Drs Thomas Aronson and Thomas Craig say cocaine apparently started a panic disorder that continued autonomously even after use stopped. While one patient achieved complete remission of symptoms through treatment with imipramine (eg, Impril), the other two patients did not return to the clinic after an initial visit because of adverse amphetamine-like effects. The researchers report two other patients at their clinic have also become intolerant of cocaine and caffeine since the onset of the disorder. The doctors note that panic attacks have been reported in as many as 64% of chronic cocaine users, and they attribute the induction of the disorder in large part to neurobiological factors.
American Journal of Psychiatry, May, 1986, v.143:643-645

Pat Rich

Substance abuse program draws students to Montreal

By Joan Hollobon

TORONTO — The students come from every conceivable background: they are teachers, rehabilitated alcoholics, prison wardens, pharmacists, ex-addicts, nurses, physicians, social workers, and housewives.

And, the University of Montreal's substance abuse program is as unusual in the breadth of its perspective as in the diversity of its student body.

"The thing we are the proudest of, really, is that we have designed a program that is not substance oriented and that is multi-disciplinary . . . . It is not even related solely to addiction, but to the use and abuse of drugs," program director Louise Nadeau told **The Journal**.

Teachers, deliberately drawn from disciplines expected to provide differing perspectives, include anthropologists, physicians, criminologists, sociologists, and psychologists. Faculty frequently include guest lecturers from Europe, generally from France.

Painting the historical background in the first of four compulsory 45-hour courses, for example, is an anthropologist, who discusses the use — not abuse — of drugs by many societies throughout history to alter states of consciousness, in religious rituals, celebrations, and so on.

Marie-Andree Bertrand, a contributor to the 1973 report of the Le-Dain commission on the non-medical use of drugs, was instrumental in establishing the program in the university's centre for continuing education in 1978, while she was vice-dean of studies.

Ms Nadeau was brought in to design and implement the program, conceived as a way of providing complementary training for those whose work requires them to deal with people having problems with any kind of drugs.

Since it is the only program of its kind in the French-speaking world, students attend from Europe, mainly Belgium, as well as Quebec.

Three other compulsory courses are physiology of psychotropic drugs, prevention, and theories and models in substance abuse, a course Ms Nadeau devised.

The theory course reviews and evaluates the different concepts of addictive behavior over the past century, that might be summed up as: sin, disease, or bad habit?

Groups like Alcoholics Anonymous (AA), for example, who see alcoholism as an incurable sickness, believe lifelong abstinence to be the only control. Others, who regard problem drinking as maladaptive, learned behavior, believe it can often be unlearned again, even to the point of resuming controlled drinking.

Refraining from espousing the disease model alone has freed the program to scrutinize many different aspects of dependency.

Nadeau: all shapes, sizes

At the same time, the disease concept remains relevant to those working in a field where AA is often the major, or even the only, treatment available. Besides, problem drinkers come in all shapes and sizes: one model cannot be expected to suit everyone, Ms Nadeau said.

The heterogeneity of the student body has advantages and disadvantages. There is value in mixing people of different backgrounds and experience, but the educational disparity can cause difficulties.

Nevertheless, feedback is encouraging: students generally praise the broader perspectives they have gained, some private Francophone treatment institutions have made the program a prerequisite for employment, and Quebec government treatment centres recommend it and will pay tuition fees for staff.

Ms Nadeau, however, is too much of a perfectionist to be satisfied, despite her enthusiasm that the 450-hour program is a great improvement over the brief summer courses generally available in North America.

But, psychotherapeutic skills require broad training and experience: addiction treatment may involve a range of psychopathology, depression, for example, that the program does not attempt to teach.

Ms Nadeau: "That is an important limitation . . . . I should like to say our students are better, but no one can say a training worth one year of university makes a professional. Now, if we could give 450 hours of training in substance abuse to people who already have a post-graduate degree, then we would have a major impact."

Traumas turn women to alcohol

TORONTO — Painful events in their personal lives are the most common cause of women's vulnerability to alcoholism, says a Montreal researcher.

Louise Nadeau, psychologist and director of a program on substance abuse at the University of Montreal, told a seminar here at the School for Addiction Studies of the Addiction Research Foundation this holds true even when the women's behavior contributes to problems, such as marital strife.

In a study of 40 women admitted to treatment for alcoholism, Ms Nadeau found 20 had long-standing marital difficulties, while others had suffered traumatic events beyond their control in the year preceding their alcohol abuse. Bankruptcies figured in the histories of four of the women.

Cases of wives of self-made men remained a study puzzle: four of the 40 study women had married men with only six to eight years of schooling, who achieved incomes of $250,000 a year.

Ms Nadeau applied the model developed at London University's Bedford College relating life events to depression among women to her alcoholism study.

Her findings confirmed other findings that family alcoholism makes an individual more susceptible to chemical abuse.

Other factors increasing women's vulnerability were traumatic events in childhood, such as parental indifference or family violence, and lack of intimacy or someone to confide in.

Study patients exhibited lower self-esteem than male alcoholics or healthy women. Ms Nadeau: "They have a self-esteem about the same as women admitted for treatment of depression."

The women also had records of more frequent admissions to psychiatric treatment, mainly for depression or other affective disorders. "But, there is a higher incidence of these problems among women anyway."

Suicide attempts also were more frequent than among male alcoholics, but this, too, holds for the general population. The difference may be in successful, or completed, suicides; it appears now from current reports that completed suicides among alcoholic women equal the rate for men, Ms Nadeau said.

Response expected soon

CRTC still mum on ad changes

HULL, Quebec — The Canadian Radio-television and Telecommunications Commission (CRTC) is expected to announce its decision on proposed major changes in alcohol advertising practices in the next month.

The changes were proposed by the Canadian Association of Broadcasters (CAB) in a draft code of ethics calling for self-regulation. The CRTC held public meetings on the CAB proposal in May and heard submissions, many against the proposal, from more than 30 agencies, organizations, and individuals.

A CRTC spokesman told The Journal the matter is still under study, with a decision expected later this month or in early October.

Instead of preclearance of advertisements by a CRTC committee, the CAB asked for clearance by the Advertising Standards Council. The council now administers voluntary codes for tobacco advertising and commercials aimed at children.

If the draft code is accepted, there will no longer be a ban on depiction of actual consumption of beer, wine, or cider — there is no liquor advertising on Canadian electronic media — or on celebrity endorsements.

NEWS AND COMMENT

The first time, 18,000 weekly listeners tuned in

Successful radio show on drugs to be rerun

TORONTO — Drug education on the airwaves was so successful, says the host of a recent 20-session radio course here, plans are underway to repeat the program this fall.

Ken Radway, host of Open College's *Drinking and Drugs: Use and Abuse*, said a broadcast survey estimates 18,000 people listened to the radio program each week from January to June this year. As a public education tool, the program was considered very successful, he said.

Margaret Norquay, director of CJRT-FM Open College, said: "We consider the total weekly listening audience quite remarkable. Our two-semester, university credit courses have never attracted more than 20,000 listeners."

The survey, by the Bureau of Broadcast Measurement, shows those tuning in to the drug education program were generally more than 35 years of age; 50% were university educated; 78% were employed full-time; 36% were business and industry executives; and, 28% were professionals.

In addition to public education, the course provided professional training for 34 people who formally registered, completed the course, and received certificates. Most were people already working in addictions who would use the certificate for job advancement, said Mr Radway, a training officer at the Addiction Research Foundation's School for Addiction Studies here.

A further 120 people received course outlines and bibliographies, but did not register formally or pay tuition.

The 20-session course will be repeated on CJRT starting October 6. Two sessions will be aired weekly: each will run on a weekday afternoon and evening and be repeated on Saturday.

The radio course, the first of its kind in the field, provides an overview of alcohol and other drugs.

Starting with a history of drugs and drug abuse, the course includes individual programs on various drugs, basic pharmacology, theories and consequences of drug abuse, drugs in the family context, and how they affect women, the elderly, and employees. Other topics are legal issues, drinking and driving, compulsive behavior, social policy, health promotion, and treatment.

Radway: public education takes to the air

GILBERT

Oriental Flushing Syndrome

. . . A tantalizing intersection of genetics, physiology, pharmacology, behavioral science, and historical analysis

In my column, Notes on the Orient (June), I commented on the apparent boisterous enthusiasm for alcohol among many of our hosts during a recent trip to China, notwithstanding reports that some 50% of Orientals exhibit the Oriental Flushing Syndrome, which is said to deter excessive alcohol use. I suggested that syndrome-sufferers may be kept away from social functions with "foreign friends." The current article in *Contemporary Drug Problems* by Julia Lee, formerly at the Pacific Presbyterian Medical Center in San Francisco, casts light on the phenomenon.

Dr Lee examined poems written in Chinese during the last three millennia as a way of examining alcohol use in China and attitudes to it. She wanted to know whether consumption had ever been greater than the present low level and whether attitudes to alcohol use had changed.

Inhibitory factor

The key question is whether Chinese drink less alcohol than Occidentals today because they find it more unpleasant. This explanation is often advanced with respect to Orientals. For example a recent study conducted at the Kochi Medical School, in which wives completed questionnaires about their husbands' drinking habits and responses to alcohol, found lower rates of alcohol-related problems among men who flushed. The Japanese authors conclude that "alcohol-induced flushing acts as an inhibitory factor against excessive alcohol use and consequent problems due to drinking."

But, says Dr Lee, if consumption levels were higher in the past, today's apparently low consumption among Chinese and other Orientals might have other causes. (She also notes that if flushing were the only deterrent to alcohol use, flushers might be expected to drink more than non-flushers. This does not appear to be true, writes Dr Lee, at least among drinkers of Chinese origin.)

That Chinese and other Orientals are more likely to exhibit facial flushing after drinking alcohol has been well documented. A recent review indicated that between 47% and 85% of Orientals flush, whereas only 3% to 29% of Occidentals flush. Flushing is associated with intense cardiac activity and peripheral vasodilation.

In one study, 10 Finnish and nine Japanese subjects were given the equivalent of three alcoholic drinks. None of the Finnish subjects and five of the Japanese subjects showed flushing. Heart rate in these five subjects increased by an average of 65%, stroke index by 23%, and cardiac index by 106%. Diastolic blood pressure decreased by an average of 23% and peripheral vascular resistance by 54%. In non-flushers, some of the effects of alcohol tend to be in the opposite directions. Heart rate may decrease for example.

The basis for the difference between flushers and non-flushers is currently an active area of research. Orientals who flush appear to lack or have an inactive version of one of the two main versions of the liver enzyme that breaks down acetaldehyde, an intermediate product of the metabolism of alcohol. The temporary accumulation of acetaldehyde in the body causes the cardiovascular effects.

Dr Lee notes that flushing and alcohol use are closely associated in Chinese written characters. The characters for drunk, happily drunk, flushed, and wine share a radical — a representation of a wine vessel.

No such etymological links exist in English. Indeed, in some 700 lines of definition of the word flush, its forms, and instances of their use in the *Oxford English Dictionary*, just one line is devoted to an alcoholic example: from a 1784 work by William Cowper, which includes the phrase "flushed with drunkenness."

Dr Lee spends much of her article pointing out the problems with using Chinese poems as a source of information. Skilled translators rarely agree on the correct interpretation of these laconic juxtapositions of signs and meanings. Chinese is a "syntactically sparse" language, even more so than English, and, even more than English, subject to ambiguity, imprecision, and misunderstanding.

Impressive collection

In spite of the difficulties, Dr Lee marshalls an impressive collection of poetic references to excessive alcohol use, drunkenness, facial flushing, hangover, and alcoholic remorse. Some poems allow precise physiological attribution. In one, facial flushing in response to wine was associated with an increase in skin temperature that released the fragrance of a princess's makeup:

"Flushed with wine she leaves her seat,
As the east grows light.
The sash at her waist is half-untied,
Under the weary stars.
In the willow-garden crows are cawing;
A drunken princess!

Her powdered face, like purple carnelian,
Hot and fragrant.
Drinking all night, asleep all morning,
Not a care in the world."

Li Ho (791-817)

Hsin Ch'i Chi (1140-1207) introduced a poem with the note: "Trying to cure myself of the habit of drinking, I wrote this poem to admonish the wine cup and ask it not to come near me." In the poem, he claims: "Things are neither good nor bad; only excess makes calamities of them. Let this be our compact: 'Do not linger, but be quick to withdraw. I am still strong enough to beat you down.'"

A 17th-century poem compares dependence on alcohol with yearning for high office:

"The world is full of those who love to be officials,
Never again can they savor the sweet taste of wine.
There are those who love wine,
They have no time to ponder how good it is to be an official.
Love of wine makes people wild,
Love of official life turns them base.
Even when his insides rot, a drinker won't quit drinking.
In the wee hours of the night, an official won't quit working.
To be fond of wine or to crave for titles,
Each in its own way can cause death.
I have always loved being an official,
A junior secretary wasn't too lowly for me.
But I'm also among those who love wine,
My cellar is always full.
This year my luck runs afoul —
Dismissed from office, I didn't do too well with wine either.
With a long sigh, I say goodbye to the capital:
I know it's time to pack up and leave!"

Ch'ien Ch'ien-Yi (1582-1664)

A reddish face in China is associated with youth as well as with alcohol use and is thus desirable. Lack of color is associated with age.

In Chongqing earlier this year, the only cosmetics we saw had been applied to young children to enhance their natural glow. A crocodile of rouged, brightly clothed six year olds visiting the local zoo was an extraordinary sight in the rain, more even than the placidly munching giant pandas or the baby panda we were allowed to play with.

In one poem quoted by Dr Lee, alcohol is explicitly deemed to be a maintainer of youthfulness. Ta'o Ch'ien (365-427) laments that when he stops drinking, "on my new face will stop the bloom of youth."

Dr Lee concludes that whereas the flushing response had likely been constant for thousands of years, alcohol consumption appears to have risen and fallen in cycles, in response to sociocultural, rather than pharmacological, factors. Even in times of excess, consumption may have been moderated by the flushing syndrome, but it is difficult to argue that the syndrome is the chief cause of the current low levels of alcohol use in China.

Added reward

The added reward that flushers gain from using alcohol in China — recapturing the lost color of youth — may have acted as a significant antidote to the aversive cardiovascular effects of accumulated acetaldehyde.

In Europe and North America, a boozed-red face is not generally regarded as pretty, nor is its chronic manifestation as a bulbous, broken-veined nose. No doubt Chinese scholars will soon be plodding through mounds of medieval prose to determine whether the fear of facial deformity was more of a deterrent against alcohol use in those dim days than in the enlightened present.

Heavy drinkers among Occidentals seem to have national characteristics — bloodshot eyes for the Irish and heavy jowls for the Hungarians — that can have little to do with genetic variation. Perhaps, diet is an important determiner of the precise depredations of alcohol on the body. Perhaps, diet is also a factor in the differences between Orientals and Occidentals.

Rulers and literati

Dr Lee notes that heavy drinking in China may have been confined to "rulers and literati, those of means and leisure." I observed that our hosts in China earlier this year — presumably fed a better than average diet — appeared not to suffer from the flushing syndrome. My Chinese friends in Toronto have suggested that sensitivity to alcohol is lost with prolonged residence in Canada, as is aversion to Canadian food.

Individuals also vary from day to day in their response to alcohol. Women in my wife's family flush violently if they drink when they are stressed, tired, or otherwise under the weather, but use alcohol with relative impunity when they are relaxed and well. "Rulers and literati" may have been less stressed or ill in historical China than rulers now, or peasants then.

The Oriental Flushing Syndrome has become a rich phenomenon, a tantalizing intersection of genetics, physiology, pharmacology, behavioral science, and historical analysis.

By Richard Gilbert

NEWS

Doctor protests BC's methadone control plans

By Paul Szabo

VANCOUVER — If the British Columbia government has its way, later this year only physicians working in government-run clinics will be licensed to treat drug addicts with methadone.

Although this proposal has been endorsed by the province's College of Physicians and Surgeons (CPS) and the BC Medical Association (BCMA) (**The Journal**, April), it angers the head of the association's drug dependency committee.

In his annual report to the BCMA here, Kenneth Varnam, MD, explained the chronology of methadone treatment in BC in the past year and his committee's recommendation that government clinics be expanded but that private doctors also be able to continue to prescribe methadone to addicts.

(Currently, there are about eight or nine government-run, BC methadone treatment clinics or programs operating; as of a year ago, there were 12 private physicians also prescribing the drug.)

New clinics, opening in the past year, "have asked private physicians treating narcotic addicts with methadone to refer their patients."

More importantly, said Dr Varnam, a letter was sent at the end of June by the province to the federal government requesting that annual licences for methadone prescribing only be granted to doctors involved with provincial drug treatment programs. The only exceptions would be doctors prescribing the drug to patients in hospital and for analgesic purposes.

Although the letter was approved by the BCMA board of directors, Dr Varnam said, "I am personally opposed to this action on the grounds it will do considerable harm to some patients."

The recommendation arose from a joint committee report in 1985 that argued better control of methadone is possible if its use is restricted to government clinics, thereby preventing illicit street sales.

But, in his report, Dr Varnam argued this is a speculative assumption and that methadone prescribed at a clinic could be, and has been, just as readily sold on the street.

Because of ethical concerns regarding the proposed move, the CPS committee on ethics is unprepared to support it.

For example, asked Dr Varnam, should patients be referred to clinics against their will, and should physicians refer patients even if they know their patients would receive inferior care? He added there is also debate about the efficacy of both the time period and the dosages of methadone used at the clinics. And, follow-up patient care is often better handled by private physicians.

Varnam: speculative

Old law doesn't control consumption

Tobacco-only stores demanded

VANCOUVER — The sale of tobacco products should be restricted to special provincial government stores, says the head of the British Columbia physicians' tobacco and illness committee.

Frederic Bass, MD, told the annual meeting here of the British Columbia Medical Association (BCMA) politicians should admit that a 78-year-old law to control smoking by young people has failed.

Dr Bass said the act, passed on July 20, 1908 in response to a smoking prohibition movement in the United States, has obviously not stopped the use of tobacco products by people less than 16 years.

Stronger actions are necessary, such as that of limiting tobacco sales similar to the way alcohol is sold.

While he admits the move would create an "enormous furor" among small store owners, he says it is still feasible.

The committee is also asking the BCMA board to consider a resolution that all tobacco be "sold in plain packages, of standard size, with the words: 'This product is injurious to your health' printed in the same size lettering as the manufacturer's name, and that no extraneous information be printed on the package."

Dr Bass said an attempt by BC physicians last year to urge the provincial government to triple the tax on tobacco products was successfully countered by the tobacco industry. Thus, the recommendation was made again this year.

Weekend prisoners given addictions help

By Betty Lou Lee

HAMILTON — Some men sentenced to weekend jail terms at Mimico Correctional Centre have it MADE.

They are being offered the option of taking an educational program about substance abuse rather than spending the time behind bars.

Mimico Alcohol and Drug Education (MADE) was chosen by 150 men last winter in a five-month pilot project and, although recidivism data haven't yet been compiled, the program has been extended to nine months this year.

The men are all serving sentences of three months or less for offences such as impaired driving, drug possession, assault, fraud, and breaking and entering.

They are usually given weekend terms because they still have jobs and families, Bernadine Bechard, an addictions educator who operates the program, explained at the 27th annual Institute on Addiction Studies, held at McMaster University by Alcohol and Drug Concerns Inc.

The men attend five-hour sessions on Saturdays and Sundays for five weekends and must remain at home the rest of the weekend.

Ms Bechard said it sometimes takes all five weekends for many of the men to admit they are more than social drinkers or recreational drug users. One businessman had spent $1.4 million on cocaine.

Figuring out how much they spend annually on drugs and alcohol and what they could do with that money is one exercise in the program. Another is working out leisure-time activities to change their lifestyles.

Sex problems, alcoholism linked

WASHINGTON — Alcoholism goes largely undetected in patients who present for treatment of sexual problems, reports a study conducted at the Sexual Behaviors Consultation Unit (SBCU), Johns Hopkins Hospital, Baltimore.

Examination of 145 consecutive patients admitted to the SBCU because of sexual dysfunction found 45 of them were "probable" alcoholics, Chester W. Schmidt, Jr, MD, and colleagues reported to the American Psychiatric Association conference here.

However, routine evaluation procedures diagnosed only six patients as alcoholic, and only one was referred to an alcoholism counsellor.

The researchers say these findings "clearly indicate the need for investigating the use of alcohol by patients who identify themselves as being sexually dysfunctional."

The SBCU study found that sexually dysfunctional men who also abuse alcohol report a high sex drive. At the same time, these men report less enjoyment with sexual experiences.

Women alcoholics with sexual problems express more joy, vigor, and sexual drive than their male counterparts.

"However, when sober, they report lower sexual drive, joy, and vigor, and increased anxiety levels. Alcohol appears to reduce these women's anxieties about sexual engagement and enhance their experience."

While relationships between alcohol abuse and sexual dysfunctions are not completely understood (**The Journal**, February), the researchers urge training staff, residents, and medical students to be alert to the presence of alcohol abuse in patients with sexual problems.

HOWELL

There's a future in urine

Consumers' Report: September, 1996

Special Report: Urine and Urine-like Products

In this special report, we look at the commerciatly availatble urine and urine-like products currently on the market and assess the purity, quatity, and efficacy of the various natural, semi-synthetic, and synthetic urines available to consumers.

Background: Urine testing of sports contestants and military personnel became popular in the late 1970s. It became a standard management tool in business and industry in the late 1980s and has maintained its popularity in this area until the present day — notwithstanding a recent trend toward polygraphs, which have the added advantage of indicating whether the employee has even thought of taking drugs. Inexpensive urine testing for the home became a reality in 1986, when a Dallas entrepreneur introduced *Alert*, an all-inclusive home detection kit for the (at the time) low price of $24.95. Of course, now, good quality Korean and Taiwanese kits are so cheap as to make weekly testing a reality in most North American homes.

The urine substitution industry had its beginnings in late 1987, as a response to demand for high-quality substitute urine that developed following the introduction of the low-priced, home and school testing kits. First into the market were high-tech companies involved in the production of 'fuzzbusters,' electronic gadgets designed to detect police radar. They were shortly followed by companies involved in the production of natural spring and mineral waters.

The industry fell on hard times during the so-called McArnay period (1989-1992), but the Supreme Court decision in the landmark Black vs Board of Education case rejuvenated the industry by effectively outlawing catheterization as a collection technique. The industry could still be hurt if the current OTTA (Observer To The Act) legislation makes its way through Congress. But, industry lobbyists are confident they can strike down the legislation's most threatening elements and preserve what industry spokesmen refer to as "the privacy of the cubicle," which they say is implicit in the First Amendment to the Constitution

The Products (*not recommended, **recommended, * superior)**

Whizaway: Whizaway is a product of Dax Industries, maker of the famous Dual Superheterodyne Maxon radar detector. Whizaway is a totally synthetic, and hence totally reliable, urine substitute. Five batches we tested passed all chemical tests with flying colors. We do caution, however, that like all synthetic urines, Whizaway's non-organic nature can be detected by gas chromatography. So, if you're going for a high-profile job in business and/or the military and you're worried about a gas chromatography follow-up to the routine chemical tests, we suggest you stick to a natural or semi-synthetic product.**

P-Plus: P-Plus is a division of Perrier Inc. The P-Plus label states that the product comes from a Mormon community somewhere in Utah. But, *Consumers' Report* has no way to substantiate that, since P-Plus insists its source community must remain secret. In any event, P-Plus passed all our tests, and we would give it a superior rating were it not for the fact there are reports of leakage from some Poly-P, pop-and-pour (Trademark registered) polyethylene ampules.**

Pseudo-P: Pseudo-P comes from Cincinnati Microwave, the maker of the top-selling *Escort* radar detector. It is a semi-synthetic, and the company claims there is enough organic product (source unspecified, but rumored to be a Pennsylvania Mennonite community) to beat the best gas chromatograph on its best day. It passed all our chemical tests and was not detected by our chromatograph. We were also impressed with the discreet packaging and the zip-lock opening for quick and easy urine substitution, even under the kind of trying conditions that will ensue if OTTA legislation gains Congressional approval.***

Pure-P: Pure-P comes from a Canadian company that got rich flogging *North Woods Natural Spring Water* to the United States public. The company uses the same marketing approach with Pure-P, claiming the product comes from remote mountain villages and northern communities where even drugs such as ASA (acetylsalicylic acid) are unknown. However, two out of five batches tested failed, being positive for diazepam (Valium) in trace amounts. Consequently, this product cannot be approved, notwithstanding the innovative, variable-amount packaging designed to foil those urine testers who automatically get suspicious when a testee produces exactly 2.5 ounces for testing.*

By Wayne Howell

Drug suspects remain vulnerable under Charter

Search and seizure: enforcement still reigns

Heather Graham

TORONTO — In July and August, 1984, The Journal published two articles on the Canadian Charter of Rights and Freedoms and its potential impact on alcohol and other drug laws.

In conclusion, Robert Solomon, law professor at the University of Western Ontario (UWO), London, and an authority on Canadian drug laws, wrote:

"During the past 75 years, Parliament has created sweeping drug enforcement powers which are far more extensive than the general enforcement provisions of the Criminal Code. For their part, the Canadian courts have broadly interpreted police authority in drug cases and have given officers a relatively free hand in exercising these powers. The enactment of the Charter will likely induce the courts and Parliament to reconsider their approach.

"At least some of the statutory search powers and tactics used in enforcing drug laws will likely be limited or struck down under the Charter. Perhaps more importantly, the Charter provides, for the first time, a public forum in which the nature of police powers and practices will be discussed."

This month, Mr Solomon, also consultant on law to The Journal, reports that during the past four years there have been several landmark Charter decisions in Canadian courts concerning, among other things, the right to counsel, search without warrant, and legislation containing a reverse burden of proof clause.

He says these decisions have had a considerable impact on federal drug laws and on federal and provincial drinking and driving legislation (The Journal, March).

However, as the following cases illustrate, the Canadian courts appear reluctant to use the Charter to protect suspects from the unsavory police practices often associated with drug enforcement.

Mr Solomon: "As in the past, our courts seem willing to sacrifice the rights of drug suspects, in their attempts to facilitate enforcement."

Case 1

The arrest: Without warning, a police constable lunged at a woman in a tavern, grabbing her by the throat with enough force to knock her from her chair to the ground. He justified the throathold as necessary to prevent her from swallowing drugs she might be carrying in her mouth.

He had no reason to believe she had drugs in her mouth and admitted on cross-examination he had no such evidence. The suspect, however, was found to have a small balloon containing heroin in her fist and was charged with possession for the purpose of trafficking.

The trial: At trial, the accused argued the search violated Section 8 of the Canadian Charter of Rights and Freedoms, which guarantees the right to be secure against unreasonable search and seizure. Furthermore, she sought to have the heroin excluded from evidence under Section 24(2) of the Charter. This provision requires a judge to exclude evidence obtained in violation of an accused's Charter rights if the admission of the evidence would, in all the circumstances of the case, bring the administration of justice into disrepute.

The decision: The trial judge held the search was unlawful and in violation of Section 8, because the constable did not have sufficient grounds to search her. But, the judge said the admission of the evidence would not bring the administration of justice into disrepute, the heroin was admitted into evidence, and the suspect was convicted.

The debate: This appeal raised several important issues concerning the legality of throatholds and the scope of Sections 8 and 24. The British Columbia Court of Appeal largely ignored the first issue and only briefly addressed the second.

The court of appeal was unanimous in admitting the evidence and upholding the conviction. Thus, the court tacitly approved police use of throatholds, an inherently violent search technique that has resulted in death and injury.

What is perhaps more troubling is the court's acceptance of the throathold, without comment, even when there was no reason to believe the suspect had drugs in her mouth. The conviction is now before the Supreme Court of Canada.

Case 2

The arrest: A suspect was arrested in a parking lot, handcuffed, and grabbed by the throat to prevent him from swallowing drugs. His clothing was searched, and he was advised of his rights, then taken to a nearby firehall where the police did a 'skin search.' The search revealed smears of petroleum jelly, which led police to believe he was hiding drugs in his rectum.

He was taken to a local hospital for further rectal searches. A doctor, also a member of the Royal Canadian Mounted Police, was asked to conduct a digital search of the suspect's anal canal. When the suspect refused consent, the doctor said police could not use hospital facilities.

At the police station, the suspect was permitted to telephone his lawyer. The suspect then told police an anal search was illegal and violated his rights under the Charter. The police replied the search would be conducted with or without his consent, using force if necessary.

During the search, a foreign object was discovered. Attempts to remove it digitally and by administering an enema were unsuccessful. The doctor then tried to use a proctoscope; this failed. The police took the suspect to another hospital where more equipment was available. Told of the potentially fatal consequences of the drug escaping into his system and knowing the police were determined to complete the search, the suspect reluctantly signed a consent form, authorizing a sigmoidoscopy.

Two officers had to forcibly hold him down. Examination revealed a balloon or bag partially hidden in the folds of the suspect's colon. Use of a Foley catheter was not successful. The police then decided against further procedures.

At the police station, the suspect was detained overnight and supplied with a make-shift toilet. The next day, he passed the heroin, the evidence was retrieved, and he was taken before a justice.

The trial: The judge held that only the digital rectal searches had been lawful: the other procedures amounted to a "cruel and contemptible abuse" of the suspect's Charter rights, and evidence obtained by such misconduct had to be excluded.

The decision: The suspect was acquitted.

The debate: While the decision is correct, the reasoning behind it is not. Police have the power to search a lawfully arrested person, but the power does not include the right to subject the accused, against his will, to surgery in the hope of securing evidence. The judge's decision was based on the extreme circumstances of the case and cannot be construed as a prohibition of surgical searches; in fact, it may infer that surgical searches are lawful provided they are not brutal.

Case 3

The arrest: The suspect was relaxing in the privacy of his office when, without warning, two police officers burst through the door. Without either a search warrant or an explanation, they rifled through filing cabinets and found 10 vials of hashish oil. Five members of the drug squad were called.

For two hours, the officers searched the office discovering four more vials. During the search, the suspect was punched in the head and kicked in the side. One officer shot out a light with a pellet gun found in the office. The officers did not inform the suspect of his right to a lawyer and repeatedly refused to let him call one.

The trial: The suspect learned the officers had sufficient information to obtain a search warrant 15 hours before the search. He contended the search, conducted without a warrant, violated his right to be secure against unreasonable search and seizure as guaranteed by Section 8 of the Charter.

The decision: The judge agreed. However, he admitted the hash oil in evidence pursuant to Section 24(2), because in his opinion its admission would not in all the circumstances of the case bring the administration of justice into disrepute. The suspect was convicted, and he appealed.

The debate: There are 82 federal statutes allowing search without a warrant. One section of the drug legislation authorizes police to search without a warrant, day or night, any place — other than a dwelling house — in which they reasonably believe there is an illegal drug. Under the legislation, the police have the power to act on their own initiative and are not required to seek judicial approval either before or after the search.

The appeal: The Appeal Court decided the search violated Section 8 and that the evidence had to be excluded because its admission would bring the administration of justice into disrepute. The decision was based on the fact the officers beat up the suspect, waved a gun around, did not inform him of his right to counsel, and repeatedly denied him his right to contact a lawyer.

The court left unresolved the broader issue of whether a warrantless search performed in circumstances in which the officers could have obtained a warrant should result in the exclusion of the evidence. To be certain of obtaining a remedy in such circumstances, it would appear that the suspect must be brutalized by the police.

Case 4

The arrest: The suspect was being held in a remand centre awaiting trial. He had not been convicted; he was presumed to be an innocent man. Without warning, he and 23 other inmates in the centre's common room were ordered to remove their trousers and underclothes, bend over, and submit to visual searches of their anal cavities. The guards claimed to be searching for forks and knives; they had no reason to suspect any inmate in the common room had concealed any cutlery or lesser objects on his person. No contraband were found.

The suspect sued the centre director seeking a remedy under Section 24(1) of the Charter of Rights and Freedoms. He claimed his Charter right to be free from cruel and unusual treatment had been violated, that intimate physical searches must be conducted in private and only performed when there is reason to believe contraband will be found.

The trial: The judge had to determine whether the search constituted cruel and unusual treatment contrary to Section 12 of the Charter. Four criteria from a case on whether capital punishment constituted cruel and unusual punishment under the Canadian Bill of Rights were considered. The judge decided these three criteria were relevant: does the conduct accord with standards of public decency; is it unnecessary because less drastic alternatives are available; and, can the conduct be rationally carried out in accordance with ascertainable standards?

The decision: The judge said the searches were not cruel and unusual treatment. His written judgment contained no analysis of the three criteria. He disposed of the claim in one short paragraph.

The debate: The judge failed to clarify the law of intimate physical searches. Men presumed by law to be innocent were subjected to wholesale, intimate, physical searches conducted in public. The judgment suggests no amount of harassment, no matter how gratuitously degrading, short of physical brutality, will be considered cruel and unusual treatment.

The case studies were prepared by UWO Faculty of Law students: *Paul Belanger, George Dolhai, Stewart Elgie, Steven Gearing, Jill Giese, Susan Inch, Beth Leaper, Michael Maddalena, Lesley Matthewson, Valerie Mutton, Penny Price, and Gordon Russell.*

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Rock's role in public forum disturbs reader

I would like to comment on the "public" forum, Rock's role in drug use: myth or reality (July).

I have been a worker on the Telecare Etobicoke telephone lines consistently for 11 years, directed some of the training courses, and manned the phones for many night hours, when the most crucial calls usually come in. I have also done a lot of work with youth via the church and at present am providing refuge for two alcoholics, one a 42 year-old man and the other an 18 year-old youth. We have provided shelter for many youth from broken homes and for children of alcoholics and drug users.

My impression of the public forum is that it was only a forum for the rock industry to defend itself. The public was at a disadvantage in not being organized, whereas the rock interests provided a united front and a power concentration at the front of the room.

I also found panelists rudely interrupted the public during the time for questions and that some of the questioners were made objects of laughter.

The doctor from the Clarke Institute urged the youth to "experiment" and said it was a healthy thing to do.

At the beginning of the session, when someone stated a rock music fan was on drugs, the situation was blamed on the parents of the youth; they were not paying enough attention to what he was doing, etc.

At the end of the session, youth were told no one had the right to tell them what they could listen to and they had a right to be "independent."

How can these two views be reconciled?

Returning home, our family sat around the dinner table discussing the forum. The young man living with us said, "Of course rock music has the effect of making someone use drugs. When you're sitting around and listening to the music, it makes you want to smoke up."

I am writing this letter to protest the manner in which the forum was conducted. If there are 'two sides,' then both 'sides' should be represented on the panel.

The conclusion of the panel seemed to be that "in the old days," it was true rock music and musicians did encourage drug use. But, now all the performers are clean and not guilty of tearing down the character of listeners, mostly pre-teens and teenagers.

I feel also that the real message in the rock videos should have been brought out — by the way, the samples shown were not typical. Rock videos give out a message of hopelessness, bondage, and persecution.

The theme of rebellion is crucial to rock music, but very harmful to the young person. Young people today have been brainwashed, conditioned to rebel against every authority.

One young spokesman said: "I don't like anyone to tell me what to do." This attitude is encouraged by the lyrics of rock music. How will this young person be able to live in a home and hold down a job if he objects to people telling him what to do? I have seen this attitude in the young people who have worked for me; they don't have to work unless they feel like it, regardless of the manager's wishes.

I am in favor of the Addiction Research Foundation holding these public forums, but feel they should be conducted in a more fair manner.

In other words, I feel the stated subject of the forum was not dealt with and there should have been an impartial moderator to help keep it 'on track.'

Margaret Sprenger
Anchor Book Store & Printing
Mississauga, Ontario

True creativity test taken in Tasmania

From (Alexandre) Dumas to (Aldous) Huxley to (Timothy) Leary, illegal substances have been used to unlock perceptive doors. However, these substances carry the risk of a pair of size 12s kicking the door in early one morning.

So it is that, as one of the more law abiding of the duller brethren in the creativity stakes, I welcomed Alan Massam's item on the power of vodka to liberate creative genius in those of us where it lies untapped (July).

Nothing ventured, nothing gained.

Now, the cardboard box presented no problem, but it was not until I had lowered the vodka to about two-thirds of the way down the label that I managed even to get the string around the cloud. Then, as I drank deeper, the sun came out, the cloud disappeared, and the string fell to the ground.

Pausing but a moment, I gathered the string up and stuffed it into the cardboard box.

Thus did creativity manifest itself:

Yon cardboard box, full of string
Now isn't that a lovely thing.
From atop the unleashed cumulus tower
Shines my new creative power.

By thee inspired, O Massam, age is young
And Poesy warbles from the faltering tongue
Thy spirit creative cheers the clouded brow
And decks the faded cheek with rosy glow.

Frank Potts
Tasmania, Australia

On international collaboration

Archibald paper wanted

After reading H. David Archibald's article (June), I am very much interested in receiving his complete text, bibliography, and lists of relevant organizations. Please send them to me.

Wayne W. Lindstrom, PhD
Bureau on Alcohol Abuse and
Alcoholism Recovery
State of Ohio
Columbus, Ohio

Please forward a copy of H. David Archibald's paper, Narcotic and psychotropic drug problems: international collaboration on health aspects (June).

I am anxious to read the paper in its entirety and explore the possibility of my participation toward the expressed objectives therein.

Lynn Damiano
TAMARC Community
Alcoholism Center
Thurston and Mason
Alcoholism Recovery Council
Tumwater, Washington

World Health Organization expert committee

Psychotropics: telling the 'good guys' from the bad

By Betty Lou Lee

HAMILTON — As this year's chairman of the World Health Organization's (WHO) Expert Committee on Psychotropic Substances, Paul Grof, MD, PhD, says the committee already has its work for the next 10 years cut out for it.

Dr Grof is professor of psychiatry at McMaster University here, and director of the affective disorders program at Hamilton Psychiatric Hospital.

This year alone his committee will review 31 barbiturates not controlled internationally by the 1961 Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Drugs, which now covers more than 140 substances.

"The WHO has a wonderful goal," he says of its health for all by the year 2000 target. "One element is that hundreds of millions of people need psychoactive drugs to help with emotional problems. At the same time, they have to build some safeguards against abuse and improper use. It's a complex problem with complex solutions, and international action can only be one element."

The process by which the WHO gets involved with a substance is also complex.

Substances to be reviewed are chosen on the basis of concerns expressed by governments, or the WHO itself. A program planning working group prepares a review plan, and consultants are hired to review all available information.

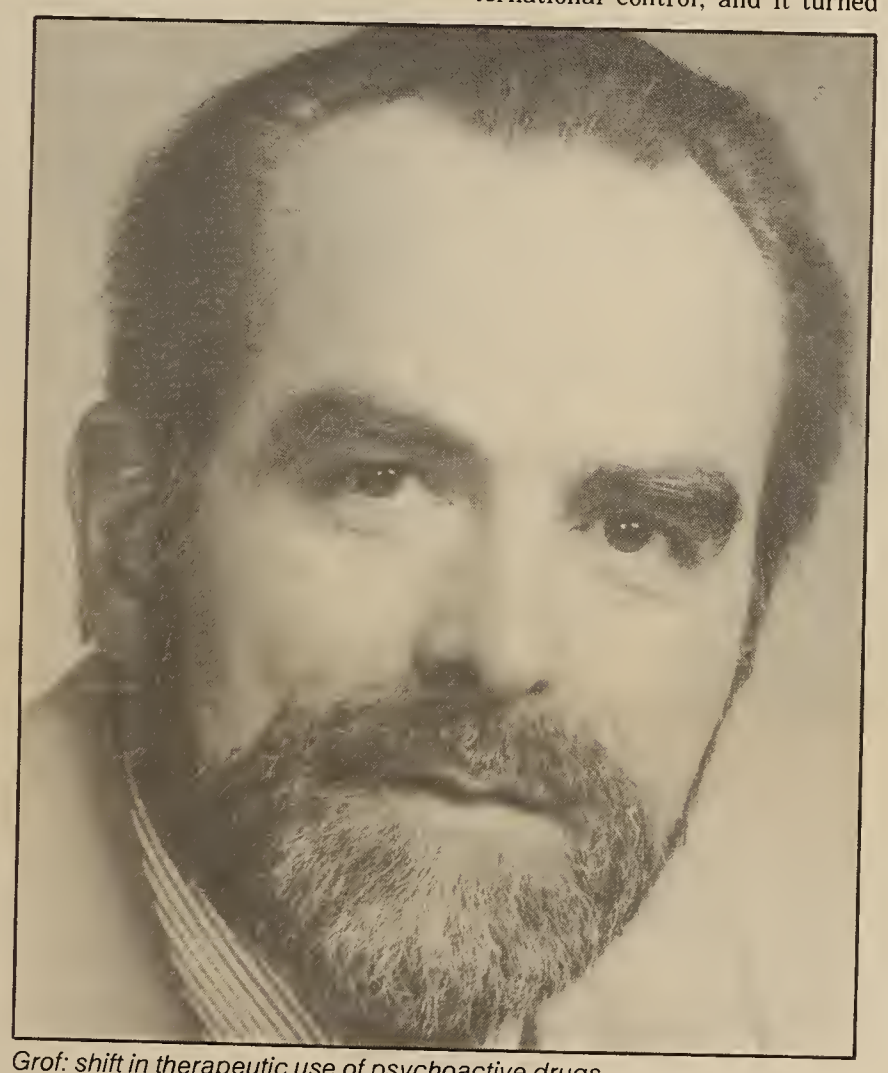
An 11-member expert committee studies the reports, making recommendations about international control, which go to the WHO director-general.

The director-general, in turn, sends his final recommendations to the secretary-general of the United Nations, and the final decisions are made by the UN Commission on Narcotic Drugs.

The resulting regulations are binding on all countries that have signed the Conventions, although each country can make the rules more stringent for internal reasons.

"The committee is supposed to deal with all psychoactive substances, and it heavily focuses on the bad guys," says Dr Grof. "The good and bad guys can change — such as nicotine — but the critical issue is what should be done. A substance could have a certain degree of addiction potential, but its benefit/risk ratio could be such that no international action is indicated.

"Anti-epileptic barbiturates are an example. People can get hooked on them occasionally, although seldom at therapeutic doses. But, their benefits are such no action is recommended.



Grof: shift in therapeutic use of psychoactive drugs

"A growing problem for the past 15 years is a certain part of the population getting access to psychoactives through relatives and friends (for whom they were prescribed). That was the case with psychoactive benzodiazepines in the 1970s and early 1980s, when they were the most widely prescribed drugs in North America."

While the medical-scientific properties of a substance — does it work, and is it safe? — are of major concern, there are socio-economic and political considerations that must be weighed.

"In some developing countries, regulation has meant lack of availability of some barbiturates, especialy phenobarbitol. It's under international control, and it turned out there was a tremendous drop in availability (for legitimate use)."

Dr Grof says in Indonesia, for example, necessary paper work costs were so high that pharmacists wouldn't stock the drug.

The committee on psychotropic substances doesn't have alcohol on its 10-year agenda.

"Alcohol is a controversial issue. It hasn't come up in our discussions in the last two years. I understand it was discussed by previous committees, and the USSR (Union of Soviet Socialist Republics) delegate took the position alcohol was a food and should not be included.

"I do not think licit substances such as alcohol, nicotine, and coffee belong on the agenda of this committee, but on the agenda of the WHO and its mental health division because of the tremendous public health implications of alcohol and the strong addictive properties of nicotine."

Dr Grof sees little hope of eliminating substance abuse "in some form" in the future. But, he does see a major shift in the therapeutic use of psychoactive drugs.

"We're going through a major conceptual shift that is seen to be as great as it was in physics in the 1920s. The interplay of body and mind is being completeley reconceptualized.

"The mechanistic approach of the body as a machine hasn't been helping; the simple idea that if you eat a certain amount of calories you have to get rid of them or you gain weight, for example. It's much more complex: regulatory processes in the body are so exquisitely well regulated and so individualized. We see people who eat tremendous amounts of food and don't have much activity, but stay healthy.

"Gradually our body of knowledge is increasing, and we have to tailor treatment more. International studies of enzymatic differences between ethnic groups are an example. Even in Toronto, Orientals need less of a psychoactive drug for the same benefit."

While there are many more drugs for mood disorders — lithium use has been considerably reduced — more non-drug treatments are emerging (**The Journal**, July).

Dr Grof says a "major breakthrough" is better combinations of psychotherapy and psychoactive drugs. In some situations, just one or two exposures to the latter can facilitate the psychodynamic processes of the former.

Magnetic therapy used by the Soviets and Germans has "dramatic effects on hormonal function, especially in the pineal gland."

Patients are also becoming more involved in their own treatment, "willing to take more responsibility for it, and to learn what they can do with and without medication. This might alter the pattern of psychopharmacology in the future."

Dr Grof, 50, began his research career after obtaining a medical degree at Charles University in Prague and a doctorate from the Czechoslovak Academy of Sciences.

He was one of the first to study lithium for the treatment of affective disorders, working closely with Dr Mogens Shou of Denmark, who was preeminent in that field.

In 1969, he was joint winner of the Anna Monica International Award for research on mental depression.

Since coming to Canada in 1968, he has been a visiting scientist at the clinical neuropharmacology branch of the United States National Institute of Mental Health in Bethesda, Maryland, a consultant to its psychobiology branch, and a consultant to former US President Jimmy Carter's Commission on Mental Health.

This year, he won the Ontario Mental Health Association's John Dewan award for outstanding research in mental health, and he was recently elected president of the Canadian College of Neuropsychopharmacology.

Institute on Addiction Studies — 27 years on

By Betty Lou Lee

HAMILTON — In 1960, a group of about 50 people, mostly clergymen, paid $35 for tuition and four days of room and board at McMaster University here to learn more about alcohol and its abuse.

The clergy were then in the vanguard of counselling alcoholics, and there were three of them among the dozen speakers at this first Institute on Alcohol Studies.

Same season, same place, 1986.

The 27th annual Institute on Addiction Studies is now a jam-packed program that runs from Sunday to Friday with as many as five simultaneous sessions. The cost has jumped to $450, and the attendance to about 150.

There's a big contingent sent by unions, many of them involved in employee assistance programs (EAPs). There's a group of officers from Canadian Forces bases and a significant number of Native Canadians. There are social workers, addiction counsellors, parole officers, personnel officers, and youth workers.

They go more than 12 hours a day: to plenary sessions, interaction groups, electives for specialized interests, seminars, and film sessions. In between, they find time to play cards, guitars, or baseball, talk shop and jog.

Some of the topics at the 1960 institute would be right at home on the 1986 program: counselling the alcoholic and his family, alcohol problems in industry, and alcohol and traffic.

But, the 1960 clergymen would be taken aback by topics like *Your body: knowing it and liking it*, given by a fitness consultant, puzzled by *Counselling the adolescent chemophile*, and aghast at *AIDS and IV drug users*.

The institutes hit their nadir in 1968, with an attendance of only 38, because they continued to focus exclusively on alcohol while the rest of society was in an uproar about street drugs and their use by young people.

The conferences were originally an educational project of the Ontario Temperance Federation, but in 1968 were taken over by Alcohol and Drug Concerns Inc (ADC), a Toronto-based volunteer citizens' group whose aim is "to encourage and promote a lifestyle that does not depend on the use of alcohol and other harmful products." ADC is widely involved in school and community preventive education programs.

"Addiction Studies" replaced "Alcohol Studies" in 1970, and subsequent programs have included such addictions as gambling, overeating, and smoking. By the late 1970s, attendance had hit 175, then it dropped slightly, due to financial restraints by governments, industries, and agencies in the early 1980s.

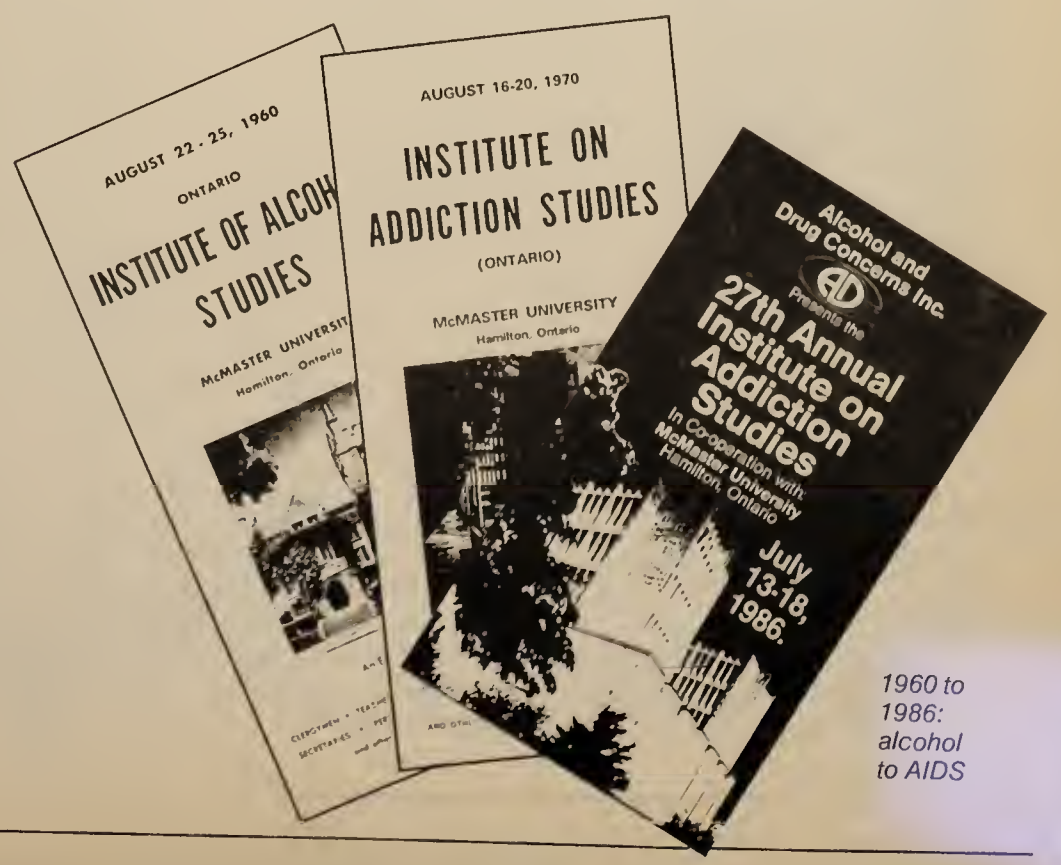
In 1978, in cooperation with McMaster, a diploma program in addiction studies was introduced. The diploma requires attendance at and written evaluations of two institutes, plus completion of two courses in related fields, or an approved independent study project.

About one-third of those attending this year's institute have been there before, and a number of them pay their own expenses.

One 11-year veteran from Windsor, Ontario, sent by his union for 10 years, is now retired from his job. But, he is still on the EAP committee so he decided to pay his own way this year.

Participants came from as far as Labrador and British Columbia.

Karl Burden, ADC executive director and course director, says ADC has been invited by a group in British Columbia to develop an institute for Western Canada, and planning meetings are now underway.



1960 to 1986: alcohol to AIDS

INTERNATIONAL

Poster: 102,000 people — a world first

Prevention campaign works — thousands 'butt out' in NZ

By Pat McCarthy

AUCKLAND, NZ — The Great New Zealand Smoke Free Week has come and gone, and delighted health authorities estimate that it encouraged more than 100,000 of the country's 786,000 smokers to give up cigarettes.

During a week of intensive non-smoking activities, surveys indicate one smoker in three tried to kick the habit, and a quarter of them abstained for one day.

"About 13% of all smokers stayed out fully for the week and intend to stay off smoking after the week is over," reports organizer Mike Kelly. "That means 102,000 people — a world first in health prevention history."

Health department spokesman Murray Laugesen, MD, says the week was probably the country's most cost-effective preventive exercise ever.

The government gave $500,000 (Cdn $363,250) to help organize the week; if 50,000 of the 102,000 who quit stay off cigarettes, the program will have cost only $10 a person.

That's "very, very cheap," says Dr Laugesen, predicting it is likely that more than 50,000 people will stop smoking permanently.

The week was supported by the national heart foundation, cancer society, asthma society, medical association, education department, health department, and chemists guild.

Carefully described as a "non-smoking" rather than "anti-smoking" campaign, the week featured a host of posters, pledge forms, bumper stickers, T-shirts ("Be nice to me. I'm trying to give up"), and a scheme for non-smokers to "adopt" a smoking friend who wanted to give up.

Twenty-one toll-free hotlines nationwide fielded an average of 500 to 600 calls a day, three out of 10 from smokers less than 16 years old.

Among political leaders to quit was Customs Minister Margaret Shields, whose department collects $368 million a year in excise and sales tax on cigarettes.

Mr Kelly, a gymnasium manager, was prompted to organize the week after an 11-year-old girl with nicotine-stained fingers enrolled for a fitness course. She habitually smoked 10 cigarettes a day.

Buoyed by the success of the campaign, he is now looking at the possibility of holding another.

Watchdog demands total ban

Tobacco ads rejected

AUCKLAND, NZ — New Zealand's official watchdog on toxic substances has recommended all tobacco advertising be banned by 1988.

Tobacco advertising is already prohibited on television, on radio, in cinemas, and on roadside billboards here. But, the Toxic Substances Board, in a report to Health Minister Dr Michael Bassett, proposes that magazine and newspaper advertising should also cease.

The board suggests banning tobacco advertising where cigarettes are sold and prohibiting signs advertising tobacco at sponsored sporting events.

Board chairman Ian Prior said the board wants the continued, multi-million-dollar promotion of tobacco, a toxic substance, to stop.

And, Dr Bassett suggests there would be considerable public support for some or all of the recommendations.

Double vision of alcohol confusing Polish public

By Peter Unwin

BUDAPEST — Polish adults have contradictory notions about alcohol, says a Warsaw researcher.

Antonio Zieliński of the Psychoneurological Institute, Warsaw, said here at the 32nd International Institute on the Prevention and Treatment of Alcohol that many Poles view alcohol as a "miraculous *aqua vitae*."

They see in alcohol "numerous nutritive, pharmacological/preventive, soothing, salubrious properties and make it a universal symbol elevating the purports of almost every ceremony."

Conflicting with this system of belief, he said, is a scientific approach. This approach strips alcohol of its mystical, symbolical meanings by associating it "with almost any social evil/crime, moral and economic vices, etc." Under this modern approach, alcohol has been left "with toxic properties alone."

His 1985 study of a sample of the Polish population found pressure by officials to present alcohol as a poison has produced much confusion within the family. "Fearing an open conflict with school and other institutions, parents tend to avoid revealing their own opinion on this subject."

In Polish society, the age of 18 years is commonly believed "to be the right age of admission to alcohol." The study notes that the lowest initiation ages were recorded for beer (16 to 18 years), while those for wine were slightly higher (17 to 19 years), and those for vodka were the highest (18 to 21 years).

A survey shows that drinking alone is foreign to Polish custom.

When asked what kind of drinking behavior is unacceptable, 89% said "an unaccompanied woman having a couple of glasses of something stronger in a bar or restaurant" shocked them "very much or slightly so." Sixty-three per cent were shocked if the drinker was an unaccompanied male.

Inducing someone who declined a drink to drink "just one more glass" was considered shocking behavior by 86% of respondents.

Permissiveness toward alcohol was generally correlated with being male, between the ages of 25 and 40 years, having a higher income, and being born in the city. Prohibitive attitudes were found to correlate with being female, in the 60-plus age bracket, actively religious, and of rural birth.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation 27,318 (Canada, 21,412, USA, 1,907; Foreign, 386, Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $24 per year
Air Mail: add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1

ISSN0044-6203 Printed in Canada

Prevention tack is critical, says UK drug chief


McConnell

Harvey McConnell, The Journal*'s Contributing Editor (Washington), reports from Britain where a major television series on drugs is being prepared. Mr McConnell comments on the campaign and speakers, including European MP Sir Jack Stewart-Clark (see page 1) and David Mellor, the chief British government spokesman on drug problems:*

The recharged war on drugs in the United States is receiving major media coverage, a flurry of Presidential and Congressional actions for demand reduction, and redoubled calls for international cooperation. Western Europe is in the midst of a crisis as well: heroin is a major problem in Britain and most of the continent. Experts think cocaine isn't far away. (See page one and The Back Page.)

Past and present officials in the US administration could be forgiven any bittersweet smiles: for more than a decade they have implored their West European counterparts for international cooperation, warning that what happens in the US will cross the Atlantic. The advice was largely ignored until recently.

In Britain, for example, along with a serious heroin problem in the inner cities, pop star Boy George has been fined for heroin possession, and the popular press has had a field day with the recent heroin overdose death at Oxford University of Olivia Channon, daughter of Trade Minister Paul Channon, and arrests on drug charges of an heir to the Guinness banking and brewing fortunes, members of the aristocracy, and the great, great grandson of Germany's Iron Chancellor Otto von Bismarck.

The British government launched an advertising campaign with the slogan "heroin screws you up" (The Journal, September, 1985), and a number of individual programs on drug use and abuse have been screened by the British Broadcasting Corporation and the commercial Independent Television network.

Another step forward is being taken this fall when Television South (TVS), the licence holder which serves a wide swath of England south of London, screens a total of 10 hours of programs about drugs, in a two-week period, in a wide variety of formats, from short segments to prime time presentations, coupled with a telephone hotline and linkups with local commercial radio stations and newspapers.

In an effort to get it right, TVS recently held a conference in Brighton, a town on the English Channel south of London, which ranks fourth in the country for the number of heroin addicts, around 3,000. Advice was sought from a gamut of those in the drug field: from police and customs officials, through psychiatrists, psychologists, and teachers, to treatment agencies and charity groups.

As well as trying to get it right, TVS producers have to wrestle with problems particular to Britain. The country's continuing economic decline and high unemployment is compounded by a class system in which private education and accent often count for more than talent and initiative. The class divisions preclude formation of any effective national pressure groups such as PRIDE (Parents Resource Institute for Drug Education), the National Federation of Parents for Drug-Free Youth, or MADD (Mothers Against Drunk Driving) found in North America.

There is also political polarization on the local level. The minority opposition Labour Party tries to project a moderate image in Parliament, but many inner city councils are in control of the party's "hard left" (Marxists), who constantly clamor against the police as "enemies of the working class."

As an example, nearly 2,000 London police were used to head off trouble in a recent raid on a "social club" notorious for drug dealing in a black area of London. The local council Labour Party leader claimed the raid was a police pretext to precipitate a riot in order to test new riot equipment and tactics.

BRIGHTON, England — Beverly Smith, executive producer responsible for the TVS drug series to be shown in November, pointed out that he and his colleagues are not experts in the drug abuse field and were at the conference to ask and to listen.

He acknowledged that recent media outbursts about drugs in Britain had a degree of sensationalism, and the clamor can obscure the reality. And in the past, newspapers and television have frequently been cavalier or just misguided.

"Nevertheless, they are powerful purveyors of information. Used well, television is the most effective form of information in the world, and it is up to us, with your help, to get it right," said Mr Smith.

Drug problems may be national and international, but they are also local and touch the hearts and minds of those who view local programs. "Where TVS can help and national campaigns can't is by being in touch with our own region" and working closely with concerned people and agencies.

An accurate picture

Mr Smith spelled out what he feels television is not capable of doing: "We can't make addicts give up drugs. Nor can we prevent youngsters from coming in contact with drugs. Television cannot brainwash them into saying no; some people may argue, but we cannot achieve it."

He and his colleagues are aware that publicity about illegal drugs may exacerbate the problem: they are honestly trying to avoid doing so by giving the TVS audience as accurate a picture as possible of the problems of drug abuse in the south of England and of agencies where help can be obtained.

Mr Smith: "We hope that an audience which is informed and rational about drugs will be better equipped and prepared to fight their growth. We mean business on this. We genuinely care. We are not in it for 'brownie points' from the IBA (Independent Broadcast Authority) or indeed from anybody else." Emphasis will be on "our region, our towns, our streets, our schools, for that localness is the true message of the facts that are so unpleasantly emerging in this so-called enlightened society."

One local campaign which made a recent impact was launched by Detective Superintendent Des Donohoe of the Dorset County Police, producers of a 15-minute video and a four-minute telephone tape giving drug information. The video includes segments by English soccer goalkeeper Peter Shilton and visiting pop groups like *Frankie Goes to Hollywood*. The telephone tape was by BBC (British Broadcasting Corporation) talk host Terry Wogan.

Out of terrible fear

Supt Donohoe, who only joined the drug squad three years ago, has now won a Churchill fellowship to study the problem in Hong Kong, Thailand, and Australia this fall.

He told the TVS conference he did not think Dorset is the worst area in Britain for drug abuse, "but our campaign and initiative was conceived out of the terrible fear Dorset could well become the worst place in the country, unless we got off our backside, as a community, and tried to do something about it."

Facts must be faced: "It is a false reality to think of putting a ring of steel around this island of ours to prevent entry of drugs. It is a laudable aim, but an impossible dream." Supt Donohoe said while police in Britain have increased their expertise in social awareness in preventing crime and in traffic enforcement, "in relation to drug abuse, we have, to some extent, been apathetic, perhaps indifferent."

It is important to remove the glamor surrounding drugs in the eyes of the young, he said, "because please be in no doubt, when young people snort cocaine, or take heroin, or smoke marijuana, the initial effects are extremely pleasurable, and it is no good pretending any differently."

Dorset police have produced an informative booklet about drugs, which each officer has to acknowledge, in writing, he has received. In addition, they produced four videos "which were not only informative, but also entertaining for police officers to watch."

In an effort to get abusers and addicts to come forward for treatment, the Dorset police chief made it public that addicts could do so without fear of prosecution.

Supt Donohoe said his colleagues know that unless the public is made aware of what is happening in Dorset, "they think, like so many other communities, that it could not happen here."

The police held a series of public meetings across the county and, with the help of local advertising and jingles on local radio stations, were overwhelmed: their first public meeting attracted 1,000 interested people and was so successful, four more were held.

In Dorset, as anywhere else, finances are tight, and the police decided to seek commercial sponsorship, "although I would hate you to think police cars in Dorset drive around with 'Fly British Airways' on them."

The police video for schools features pop stars and sporting giants. "It was not made for your benefit or mine, but for the youngsters to watch." It is only the beginning: parents and communities in Britain must start working together to fight the drug menace.


Boy George: and Oxford


Mellor: taking root

David Mellor, British undersecretary of state at the Home Office and chief government spokesman on drug issues, told the conference: "We have a chance, if we act together, to effectively stop the misuse of drugs from really taking root in our community. It is clear once drugs have taken root, it is extremely difficult to dig them out."

Britain, like many countries, has had a drug problem of one dimension or other for generations. But, in approximately 1977, heroin spread from beyond the deviant fringe when it was found heroin could be smoked. Today, this is coupled with the added dangers of cocaine.

"We know from what is happening in the US with cocaine that if we fail to take the messages, then we shall deserve all that we get."

No single answer

Mr Mellor: "There is no one single answer to the drug problem, no one single lever on the wall, even one with a huge price tag attached, that you can pull and rid yourself of this problem.

"The only way to tackle this is to range across the whole subject, starting in the countries of origin of drugs, going through all of the law enforcement procedures, and ending up with what I have come recently to regard as the most crucial thing: prevention."

Britain, like other countries, is involved in a number of international programs, "but I think we have to be very clear about one thing: if you are a peasant farmer with a subsistence level economy and the only crop someone will buy from you is opium, it is difficult for us in the West to pass off too many moral objections to them actually doing that. We have to provide people everywhere with a range of choice."

There is no question "international cooperation is not an option with drugs, it is a necessity, because the drug trafficker is a man of the world himself. He exploits the incoherencies of national responses in order to get away with it."

Alcohol must also be included in any program about drugs.

Mr Mellor: "I tell parents that if you need three or four stiff gin and tonics to get through your evening, you are not exactly occupying moral high ground as far as telling your kids to keep off what they might want in order to get themselves through the evening."

He took issue with the claims by some in Britain that drug use is a problem of individual failure, or a problem of poor conditions, especially housing.

"Poor housing wasn't Boy George's problem, nor was it a problem for the heir to the Duke of Marlborough."

FEATURE

Alcohol, other drug addiction, mental illness

EAPs: good systems face the real problems

VANCOUVER — Employee assistance programs (EAPs) that exclude direct reference to addictions are only paying "lip-service" to the essential principles on which they should be based, says Don Baran.

And, Mr Baran, who pioneered an EAP for the Royal Bank, knows a winning formula, for both the company and its workers, "has to be up front and deal with the most difficult problems," alcohol, other drug addiction, and mental illness.

It is this approach which has made the Royal Bank program one of the success stories of the EAP movement in Canada.

In its first four years since going nationwide, the program has dealt with almost 3,000 employees (about 8% of the bank's total number in Canada). And, Mr Baran, manager of the EAP, told the 1st Western Conference on Alcohol and Drug Abuse here, "the bulk of them got well."

There are obvious benefits for the company: 80% of those who "got well" stayed with the bank.

Paul Szabo *reports on the program for* **The Journal**.

At the core: altruistic desire to help

ACCESS

Bank's EAP logo

To find the beginnings of the Royal Bank EAP, one goes to Winnipeg.

Mr Baran explains: "Back in the early 1970s, as a personnel manager, I found myself faced with some alcoholic managers. I didn't know they were alcoholic. All I knew was that they had drinking problems. And, the drinking problems resulted in problems on the job.

"I called them in and used the big stick — shape up or ship out — because I thought that was all you had to do. . . . Within a matter of months they relapsed, and I realized I didn't know what the heck I was doing. I was missing an essential ingredient it turned out, that being where to send them for help."

When he reported to his supervisors that the bank had lost two excellent staffers with a total of 46 years banking experience, Mr Baran was told he was just the last in the line of people who had tried to deal with those employees.

Wanting to find out how to do more in such circumstances, he became involved with staff from the Alcoholism Foundation of Manitoba in 1971. They helped him put together a small program for Royal Bank employees in the area.

Baran: essential principles

An occupational alcoholism model was developed to treat employees who needed help.

"From that, we learned."

The program received a number of management referrals of employees, but no self-referrals. The fact he was the personnel manager and the EAP coordinator was not very conducive to self-referrals, Mr Baran says.

When he moved to the bank's head office in Montreal in 1976 as manager of corporate personnel, he was asked to bring along the same basic EAP ideas.

In 1979, he was given a mandate to organize a head office EAP. The program was launched in April, 1980 and encompassed all bank employees working in Quebec. Three months later, the program was extended to the Maritime provinces, and in 1981, to British Columbia, the prairie provinces, and Ontario.

The program continued to expand — in 1982 to the United States, in 1983 to the United Kingdom, and late in 1983 to the Caribbean.

In 1984, Mr Baran says, "we came to the realization that as our case load was growing by about 500 cases a year, we had to make a strategic decision to either double the staff or look elsewhere."

The bank chose to go to an outside EAP supplier, Comprehensive Care Corporation in the US, which could provide 24-hour assistance through a call centre. There had been definite problems with the bank EAP being solely an in-house program, only able to provide help from Monday to Friday, 9 am to 5 pm. This left employees to fend for themselves the rest of the time.

So, that year, CompCare EAP Service Corporation was established in Canada. Bank employees can now get help on a 24-hour a day basis, using a toll-free number. Employees are referred to any one of five CompCare centres in major Canadian cities or to addictions or mental health centres designated as CompCare consultants in their areas. Troubled employees are never more than 100 kilometres away from treatment, Mr Baran says.

He adds that the concept of a call centre for initial catchment of employees needing assistance "works." Program utilization has more than doubled in the last year.

The stated purpose of the Royal Bank's EAP — known as ACCESS — is "to protect the employment relationship by providing help to hurting people before the difficulty begins to impact on the job."

Mr Baran: "By the time a person's problems begin to interfere on the job, a lot of them are dying. There has to be a way to get there before that happens."

Although it's a program established and largely paid for by a company (employees, spouses, and immediate family are covered for the full 100% of treatment for alcoholism and other drug addiction, and 50% of the treatment for mental health problems), there is still at the core an altruistic desire to help people with problems.

The bank makes it clear employees have a responsibility to seek help if they have a problem. From the program literature: "Failure to take action to overcome a personal or behavioral health problem which is affecting job performance can lead to disciplinary action."

Mr Baran adds: "Just because you're getting help from the EAP does not mean you can walk away from your responsibilities."

Much of the emphasis of the program is to raise employees' awareness of problems relating to alcohol and other drug abuse and mental illness through education.

"For people showing early signs of dysfunction, we have found if we can present information they can accept and acknowledge by looking in the mirror, we can help crack the denial system."

Mr Baran says basic drug information is incorporated in EAP educational sessions. He cautions assumptions should never be made about employees' awareness about dependency issues.

When the bank first started its nationwide EAP, he estimated "somewhere between 5% to 10% of our staff were troubled and could use the program in one way or another." As of October, 1985, the program had dealt with 2,817 employees, about 8% of the total of 36,000 Canadian employees. "The bulk of them get well," Mr Baran reports.

Twelve percent of the bank's managerial staff sought assistance through the program and 7% of non-management employees. Mr Baran is particularly proud of the success of the program in involving management personnel, a group which he thinks many EAPs miss.

A breakdown of some of the clients seen shows 3.8% had been referred for drug problems, 15.5% for problems with alcohol, 26.4% for problems related to family, 34.2% for emotional problems, and 20.1% for other concerns such as housing. Many of the family and emotional problems could be traced back to alcohol or other drug abuse problems in the home.

Demographics of people seeking help show ratios match almost exactly sex and age groups within the total employee population.

Since the EAP began, the mix of problems employees seek help for has changed.

"When we first started, we put so much emphasis on education on addictions . . . a year and a half after we began the general corporate program, 46% of our problems were alcohol (related). As we moved more broadly into mental health issues, promoting the family, and so on, the profiles started to change somewhat. In the last few years, more than 30% are emotional and mental health problems."

A large percentage of such problems can still be traced to the root of an addiction which has led to the emotional disturbance.

There are obvious benefits for the company in a successful EAP. Mr Baran says many employees using the Royal Bank EAP have been traced, and 80% of those who "got well," have stayed with the company.

From his perspective, Mr Baran expresses concern with some of the other EAPs now operating in Canada.

"I am distressed with what I see in a lot of program material published these days."

He accuses some companies of only paying "lip-service" to the essential principles of an EAP.

"I'm seeing them talk about personal and family problems. I see them completely exclude words like alcoholism, drug addiction, and mental illness. And, I think that's tragic. If we don't put such words up front and help de-stigmatize them by corporate recognition of their reality and their treatability, a lot of suffering people end up in the revolving door and don't get the help they truly need.

"If the corporate policy statement excludes such words, the impact of the program is dramatically reduced.

"I believe, basically, that a program has to be up front and deal with the most difficult problems."

Many EAPs are not succeeding. "When we look at their numbers, their utilization, and their success rates with addictions, they're only minimally successful.

"The reason is that many of the people promoting the programs have no training whatever in addictive disease. None. And they're missing. They're dealing with the family problem, dealing with the emotional problem, dealing with the financial problem, but not dealing with what's causing it."

While a number of Canadian companies have EAPs on paper, the delivery is lacking. Mr Baran estimates about 5% of Canadian companies have effective EAPs, and there are only about a dozen really good programs in the country.

For Mr Baran, there are important principles behind a successful EAP: making employees aware of the program, and ensuring confidentiality. Employees hesitate to become involved in a program through a personnel department — where they fear their records will be available to their supervisor.

ROYAL BANK

Mr Baran says also treatment should be managed by outside professionals. While third-party audits are arranged by the bank to make sure that eligible employees are being treated, all medical information bypasses the bank completely. No feedback is given to management unless it is given by the employee concerned. This makes employees comfortable with using the program, he said.

Self-referral is also highlighted in the Royal Bank system. But, management staff are also counselled on spotting those who might benefit from the program.

"We train our managers . . . to keep alert to the realities of a troubled person."

Access, lifestyle issues affect planning

Alcohol policy needs prevention input

By Terri Etherington

BUDAPEST — Both increased access to alcohol and the growing trend toward integration of drinking into everyday life make the work of those in the prevention field more difficult.

And, says Norman Giesbrecht, PhD, those responsible for the health and social aspects of alcohol abuse should be involved in planning changes in access, as well as dealing with the consequences. Prevention efforts should also recognize that drinking styles have undergone change.

"A case can be made for higher priority for prevention initiatives that focus on control and regulation," he told the 32nd International Institute on the Prevention and Treatment of Alcoholism here.

Dr Giesbrecht, a scientist in the alcohol policy research section, Addiction Research Foundation, Toronto, outlined recent trends in alcohol control and drinking styles in Ontario.

The introduction of self-serve liquor stores and winery kiosks in the last decade has now been followed by a proposal to allow the sale of beer and wine in grocery stores (**The Journal**, November, 1985).

The proposal, said Dr Giesbrecht, would add approximately 6,000 outlets to the off-premise network (an increase of about 600%) and would alter the traditional government-monopoly approach, putting the sale of alcoholic beverages in the hands of the private sector.

There has also been a dramatic increase in the number of licenced premises, beer sales have been allowed in three large sports stadiums, and special-occasion permits have proliferated.

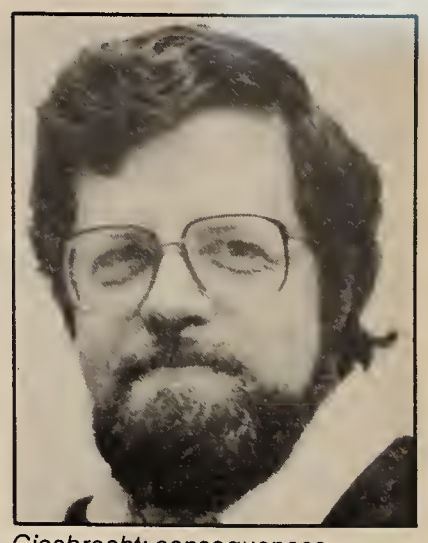
Lifestyle alcohol advertising, the promotion of lower alcohol content in beverages such as 'pop' wines, wine 'coolers' and light beer, as well as sponsorship of sporting events by brewers and distillers, have all escalated in the past 10 years.

"Almost all these changes have been in the direction of greater access either explicitly or indirectly," Dr Giesbrecht said.

"It would appear that these changes make alcoholic beverages more attractive to new drinkers, or drinkers with 'discriminating' tastes and preferences, and also offer greater convenience and socially 'normal' contexts for the heavier consumers."

Dr Giesbrecht suggested prevention efforts could include:

- establishing a higher profile for municipal procedures on regular licence applications and encouraging discussion of the implications of expanding the number or capacity of outlets;
- developing new municipal policies on special-occasion permits, such as designating a service club to oversee and regulate all functions where permits are granted;
- increasing public awareness of current developments and of initiatives that would change access to alcoholic beverages; and,
- increasing public awareness of the consequences of drinking.



Giesbrecht: consequences

Use/abuse labels become blurred

BUDAPEST — Alcohol policy should focus on abuse and not use, says the public relations director for Canada's distillers.

Kay Kendall told the 32nd International Institute on the Prevention and Treatment of Alcoholism here "the distinction between use and abuse is becoming blurred.

"That distinction is the difference between millions of Canadians who use alcohol and do so appropriately, moderately, and the small minority who cannot enjoy the benefits of drinking without abusing alcohol.

"Far from representing a social deviancy that is comparable to illegal drug abuse, responsible drinking is, in fact, mainstream Canadian behavior."

Ms Kendall is with the Association of Canadian Distillers, a group of 12 companies.

Kendall: mainstream behavior

She told the conference the distillers "prefer education programs to severely restrictive measures and feel the former are more effective."

Ms Kendall: "Some restrictions are, of course, necessary. The point of the debate is where one should draw the line and say, 'Beyond this, the laws are too restrictive and may even become counterproductive.' In a certain sense, this entire conference could be seen as a debate on where society should draw the line."

The distillers, she adds, believe control and prevention efforts should concentrate on the individual, 'the host,' and not alcohol, 'the agent.'

"It remains as fact that there are certain people at greater risk of developing alcohol problems, and the best approach to alleviating the problems is to learn the most efficient ways to reach those individuals."

Internists can spot alcohol abuse but stop short of care or follow-up

WASHINGTON — Physicians and primary care internists are better at screening alcohol abuse in their patients than they are at arranging adequate follow-up and referrals.

And, part of the problem stems from negative attitudes among faculty mentors and residents, which are reflected in informal practice standards whereby alcoholics are neither "given, nor regarded as deserving of, a physician's best efforts."

Wayne Mitchell, PhD, Troy Thompson, MD, and Steven Craig, MD, collected data from medical charts of 163 patients consecutively admitted to University Hospital, Denver, the major teaching hospital of the University of Colorado School of Medicine.

They told the American Psychiatric Association meeting here 78% of the patients in the study were evaluated as alcohol abusing, or at least, abuse was noted. Alcohol abuse was discussed with 85% of the abusing patients.

However, "the relatively small percentage of consultations or referrals (21%) that followed, suggests either that the initial discussion was unsuccessful in convincing patients to accept further help or that the physicians did not think additional services would be helpful or were necessary.

"Whatever the reason, the result often was a failure to treat adequately and follow-up on alcohol abuse."

The study lists four rationalizations often given by internists for avoiding alcohol disorders:

- their job is to care for biomedical, not psychiatric, problems;
- they do not have enough time to deal with such patients;
- talking with patients about such problems should be avoided because it will be too painful and upsetting for the patient; and,
- it is a waste of time to address these problems because they are beyond the internist's capacity to treat.

While the researchers admit specialized alcohol abuse treatment may be beyond most physicians' training, they say "this does not dismiss their responsibility to diagnose the problem and to seek appropriate consultation from a psychiatrist or other alcohol abuse specialist."

By consulting with psychiatrists, physicians would be reminded "resistance and provocations (of alcoholic patients) are as much a part of their disease as is damage to the liver or central nervous system."

New Books

by MARGY CHAN

Employee Assistance: Policies and Programs

. . . by Gail G. Milgram, Barbara S. McCrady

One of the first titles in the Center of Alcohol Studies pamphlet series, this brochure is designed to provide clear, concise, and relevant information on selected topics of current interest. The contents explain employee assistance programs, their history, and structure. A bibliography and a list of additional readings are appended.

Center of Alcohol Studies, Rutgers University, Piscataway, New Jersey. 16 p. $2.50.

Counselling the Alcoholic Group

. . . by Joseph F. Perez

This book is designed to help counsellors function effectively as leaders for alcoholism groups. It focuses on the group process, dynamics and personal commonalities of group members, functions of group leadership, fundamental techniques to facilitate a group, and therapeutic activities for a group.

While there are many books written on the group process, this one stands out for addiction professionals because it focuses exclusively on the dynamics and problems peculiar to the alcoholic group.

The book's format and the language used are easy to understand. Each chapter is followed by a summary and a list of references.

Gardner Press Inc, New York, NY. 145 p. $23.95. ISBN 0-89876-131-X.

Other books

Are You Dying for a Drink? Teenagers and Alcohol Abuse — L. Graeber, 1985. Written for teenagers, the book discusses what it is like to be a teenager who drinks too much and is likely to become an alcoholic, why teens drink, alcohol's effect on body and mind, drinking and driving, and living with alcoholic parents. Julian Messner, New York. 160 p. ISBN-0-671-50818-0.

Inside an Emotional Health Program — William J. Sonnenstuhl, 1986. Subtitled "a field study of workplace assistance for troubled employees," this book documents the progress of individual clients and examines the internal workings of such a program. ILR Press, Ithaca, New York. 187p. $10.95. ISBN 0-87546-120-4.

Intervention: How to Help Someone Who Doesn't Want Help — Vernon E. Johnson, 1986. Written in readable, non-clinical language, this book is a step-by-step guide for families and friends of chemically dependent people. Johnson Institute Books, Minneapolis. 116 p. ISBN 0-935908-31-5.

Kids, Drugs and the Law — David G. Evans, 1985. The book discusses major legal issues that occur when children use or misuse alcohol and other drugs. References are made to laws in the United States. Hazelden, Center City, Minnesota. 84 p. ISBN 0-89486-283-9.

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Cocaine Diary

Number: 743.
Subject heading: Cocaine/drugs and youth.
Time: 23 min.
Synopsis: Chris and his girlfriend are excited because he has saved almost enough money to buy a car. Rob, Chris' brother-in-law, with whom Chris is continually compared unfavorably, urges Chris to join him for a ride in his flashy new car. During the ride, Rob gives Chris some cocaine, telling him that this is how he stays up and on top of everything. Chris quickly gets into the habit of using cocaine. His girlfriend, however, does not like what is happening and recounts the events in her diary: his hanging around with other drug users, his wild mood swings, his squandering all his savings, and his dealing in cocaine. Chris' sister leaves her husband, because of his drug abuse and consequent financial difficulties. Chris confronts Rob, calling him pathetic and claiming he will never be like him . . . but Chris' girlfriend is not so sure.
General evaluation: Good (4.2). This well-produced, contemporary film could lead to good discussion about the use of cocaine among teenagers. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit teenagers and parents.

The National Alcoholism Test

Number: 744.
Subject heading: Alcohol/alcoholism overview.
Time: 22 min.
Synopsis: Patrick O'Neal asks a series of 12 questions about the warning signs of alcohol abuse, such as morning drinking, memory loss, and remorse after drinking. Former problem drinkers answer the questions based on their own experiences. Interspersed between questions and answers are facts about alcohol consumption and its effects on society. Mr O'Neal urges anyone who answered "yes" to three or more questions to seek help for his/her problem.
General evaluation: Very good (5.0). The question-answer format is well presented; the respondents are believable and articulate. The film was judged a good teaching aid and could assist viewers in identifying drinking problems. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit audiences 15 years of age and older.

Sound of Silence

Number: 749.
Subject heading: Alcohol and the family.
Time: 26 min.
Synopsis: Claudia Black talks about the violence to which children of alcoholics are subjected and their difficulties in talking about it. Young children, and adult children of alcoholics, talk about how physical, sexual, and emotional abuse have affected them. They suffer emotional problems, have difficulty relating to others, and often become alcoholics or marry them. Others report, although they were not the actual targets of abuse, they were damaged by family members being abused. The way to stop this problem is to "break the silence" and talk about it.
General evaluation: Good to very good (4.7). This film might be emotionally upsetting to some viewers, but the people in the film are so real and have such important information to impart that it is a good teaching aid. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit parents, adult children of alcoholics, and health care workers.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Canadian Psychiatric Association Meeting — Specificity in Psychiatry — Sept 24-25, Vancouver, British Columbia. Information: Lea C. Métivier, chief administrative officer, 225 Lisgar St, Ste 103, Ottawa, Ontario K2P 0C6.

Introductory Addictions Management Course — weekly, from Sept 24-Nov 26, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Orientation to Detoxication Services — Sept 29-Oct 3, Jan 26-30, 1987, April 27-May 1, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May Street, Toronto, ON M4W 2Y1.

Annual Conference Canadian Association of Social Work Administrators in Health Facilities — Sept 30-Oct 3, Montreal, Quebec. Information: Jill Dalibard, Ville Marie Social Service Centre, 4018 Ste Catharines St, West, Westmount, PQ.

The Troubled Employee: Intervention in the Workplace — Oct 1-3, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Workplace 86 — Beyond Awareness: Emerging Issues — Oct 1-3, Edmonton, Alberta. Information: Alberta Alcohol and Drug Abuse Commission, community education services, Ste 803, 10109-106 St, Edmonton, AB T5J 3L7.

Ontario Hospital Association Conference: Care for Patients with Alcohol and Drug Problems — Oct 3, Toronto, Ontario. Information: Gwen MacKinnon, education consultant, Hospital Outreach Service, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

American Association for Automotive Medicine Annual Meeting — Oct 6-8, Montreal, Quebec. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Addiction and Family Violence — Oct 18, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Counselling Communication Skills Course — Oct 27-31, March 5-April 23, 1987 and July 6-10, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Social Science Federation of Canada Research 86: Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario K1A 0N5.

15th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology — Nov 2-6, Quebec City, Quebec. Information: Mary Lynn Moffat, CAG/head office, 1080-167 Lombard Ave, Winnipeg, Manitoba R3B 0V3.

The Children of Alcoholics: A Canadian Conference for the Helping Professional — Nov 16-18, Toronto, Ontario. Information: Children of Alcoholics conference, PO Box 159, Station H, Toronto, ON M4C 5H9.

Event 86 — Skill Development and Training for Employee Assistance Personnel — Nov 16-20, Oakville, Ontario. Information: James Simon, Addiction Research Foundation, Georgian Bay Centre, PO Box 936, 100 Bell Farm Rd, Barrie, ON L4M 4Y6.

Drug Education Coordinating Council 4th Annual Conference — Nov 20-21, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

Canadian Addictions Foundation Annual General Meeting — Nov 21-22, Edmonton, Alberta. Information: CAF head office, 4254-93 St, Edmonton, AB T6E 5P5.

United States

New York State Council on Alcoholism Annual Meeting — Sept 18-19, Albany, New York. Information: Sherrie Gillette, New York State Council on Alcoholism, 155 Washington Ave, Albany NY 12210.

Children of Alcoholics — Sept 25-27, Chattanooga, Tennessee; Oct 16-18, Phoenix, Arizona; Nov 6-8, Houston, Texas; Nov 13-16, Los Angeles, California. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Marijuana Dependence: A National Conference — Oct 3-4, San Francisco, California. Information: Raymond J. Brown, Marketing Consultant, Henry Ohlhoff Counselling Center, 2418 Clement St, San Francisco, CA 94121.

Alcohol-Related Birth Defects: Implications for Policy— Oct 19-21, San Diego, California. Information: Alcohol-Related Birth Defects Conference, University of California, San Diego X-001, La Jolla, CA 92093.

National Federation of Parents for Drug-Free Youth 5th Annual Conference, Networking America for Drug-Free Youth — Oct 9-11, Washington, DC. Information: Mary Jo Green, 8730 Georgia Ave, Ste 200, Silver Spring, Maryland 20910.

Northeast Conference on Addictions: The Chemically Dependent Family — Oct 26-29, Albany, New York. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Improve Your Group Counselling: An Advanced Skill Building Seminar — Oct 28-30, Houston, Texas. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

The Age of Geriatric Rehabilitation Perspectives and Potentials — Oct 30-31, New Hyde Park, New York. Information: Ann J. Boehme, associate director for continuing education, Long Island Medical Center, New Hyde Park, NY 11042.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Nov 3-6, Dallas, Texas. Information: Judith Evans, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

American Association for Advancement of Behavior Therapy Annual Meeting — Nov 13-16, Chicago, Illinois. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

14th Annual Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Nov 17-21, Boston, Massachusetts. Information: Kristine Niven, administrative associate, Center for the Study of Drug Development, Tufts University, 136 Harrison Ave, Boston, MA 02111.

SECAD XI: Southeastern Conference on Alcohol and Drug Abuse — Dec 3-7, Atlanta, Georgia. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, 11050 Crabapple Rd, Ste D-120, Roswell, GA 30075.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, 1987, Orlando, Florida. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Abroad

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, dept of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

World Conference on Addiction — Oct 19-25, Vienna, Austria. Information: Barbara Turner, conference coordinator, Bldg D, Ste 120, 11050 Crabapple Rd, Roswell, Georgia 30075.

Alcohol Problems in Celtic Countries — Oct 30-Nov 2, St Peter Port, Guernsey, Channel Islands. Information: P.J. Lemmon, Guernsey Council on Alcoholism, 50 The Bordage, St Peter Port, Guernsey, Channel Islands.

Society for Prevention of Drug Abuse 1st Scientific Congress: Problems of Drug Addiction —Nov 3-4, Warsaw, Poland. Information: Congress organization committee, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warszawa, Poland.

11th World Congress for Social Psychiatry — Nov 6-11, Rio de Janeiro, Brazil. Information: J. Alberto Costa e Silva, Faculdado de Ceincias Médicas, Hospital de Clinicas, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil.

International Federation of Non-Governmental Organizations for the Prevention of Drug and Substance Abuse 8th Annual Conference —Dec 13-19, Sydney, Australia. Information: Chairman, program committee, PO Box 477, Canberra City ACT 2601, Australia.

7th International Conference on Alcohol Problems — April 5-10, 1987, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

Prevention: a way of life in Finland

HELSINKI — Prevention can work: the Finns have proven it.

Finnish police can't make undercover drug buys. They can't even tap telephones. And, it's an inexpensive overnight ferry trip to Stockholm, or an hour or so by plane to Copenhagen, where drug use and trafficking are rampant.

Yet, Helsinki, Finland's largest and capital city, by the standards of the rest of Western Europe, much less North America, does not have a major problem with drugs.

It is not because Finns are temperate — alcohol abuse here is an enormous problem — but because of prevention and education programs that work, strong laws, constant police vigilance, and international cooperation, as Helsinki Police *Commissaris* (detective superintendent) Antii Turkama explains to Washington contributing editor Harvey McConnell.

Helsinki: virtually drug-free

A stranger can judiciously ask around Atlanta or Athens, Calgary or Copenhagen, Los Angeles or London, Miami or Munich, Toronto or Turin, and not take too long to find a cafe, bar, club, pub, saloon, shop, street, or alley where drugs can be bought.

A similar search in Helsinki would be in vain: "I don't know" is always the reply. And, Finns who do know never, ever, tell a stranger, foreigner, or fellow Finn.

"We have tried to make it that there will be no known spot in the city where you can buy drugs. I think we have succeeded," explains Antii Turkama, deputy head of the Helsinki police narcotics bureau.

Experienced Helsinki journalists agree.

And, the success of the police is accomplished without telephone tapping, although that might change, and undercover buys, both now illegal in Finland.

There are no official statistics, but it is estimated there are only about 10,000 chronic drug users in Finland, a majority of them living in the Helsinki area of approximately half a million people.

Cannabis, mainly hashish smuggled in from Sweden, Denmark, the Netherlands, and Morocco, at present accounts for 68% of the drug arrests by police (amphetamines 10% and heroin only 2%). Cocaine is coming, but the commissaris and his colleagues know it and are preparing.

Drug use among the five million Finns is small compared with alcohol problems, but it is not for want of trying by traffickers. Major barriers here are strict laws legislated in 1969 in response to a serious amphetamine problem, determined prevention and education programs, and international cooperation.

Closed border

Geography helps too: the conduit of drug popularity runs from North America to Western Europe then up to neighboring Scandinavian countries, especially Denmark and Sweden, before reaching into Finland. On the east, from the Arctic to the head of the Baltic, is the Soviet Union and the closed, although not drug-proof, border.

Commissaris Turkama, whose languages include English, is in daily contact with his Swedish and Danish counterparts and in frequent contact with the United States Drug Enforcement Administration agent in Copenhagen and the Royal Canadian Mounted Police agent in London.

He frequently attends conferences abroad. In 1985, he studied the situation in the US in a month-long, coast-to-coast tour with 19 other foreigners, not all police. It was arranged by the US government.

Softly spoken, with a penchant for cigars, Commissaris Turkama gives the impression of a fictional continental detective, Nicolas Freeling's Van der Valk or Georges Simenon's Maigret: urbane, polite, patient, and an incisive interrogator and investigator.

Commissaris Turkama thinks Finland, with respect to drug control, got the jump on most other Western countries "because we were able to start control policies rather earlier."

The problem, in 1969, was amphetamine abuse by long-time, adult users, who were importing it from Sweden and the Netherlands and pushing it on young people. Parliament acted: it was made illegal to consume or possess any illegal drug.

Traffickers cut off

The police have cut off efforts so far by West European traffickers trying to establish networks in Finland.

All of this has had an enormous impact on demand. "Young people understand Finnish society does not tolerate the use of narcotic drugs and that, if they do use them, there will be consequences in court. If you are a user, then you are a criminal."

The amount of drug involved makes no difference: arrest, questioning, a search of the home, and then a court appearance follow. The courts, of course, take into account the amount of drug when passing sentence, but "the whole process is a very strong expression from our society that you have to be serious when you desire to use drugs in Finland. You know you are breaking the law."

Prevention and education programs are constants in Finnish schools. A special cadre of young police men and women regularly visit to discuss a wide variety of topics, including drug use, and during the summer vacation, some of them spend time in the narcotics bureau with the 40 full-time narcotics officers.

First-time cannabis offenders usually get a warning and possibly a small fine. A suspended sentence — although it can be as high as two years — can be meted out for more than what is considered personal possession. But, possession of, say, half a kilo of cannabis is considered an aggravated narcotics crime; the penalty can be from one to 10 years in jail.

Most drug users are in the 20 to 30 year age bracket. There is little drug abuse — except alcohol — among middle-aged Finns. But, there is some among the elderly: for those wounded in World War II, morphine was one of the few available drugs.

He says police have had no drug cases this year of anyone less than age 15 years and only a few cases of those aged 15 to 18 years. There is also little drug use among college students.

He talks to every teenage drug user arrested, as well as to their parents — who are often shocked and unbelieving at first.

Finnish students abroad on scholarships or officially sponsored trips are told they are entering countries where the climate is different on drugs and to be prepared to see it if they attend a number of parties.

Most of the adult drug users in Finland "are in a poorer situation than the average citizen. They may be unemployed, or without an apartment: the usual story in a way."

Commissaris Turkama and his colleagues have no doubt long-time users turn to crime, because honest work won't pay for the high prices of drugs in Finland: one gram of hashish is about $20, and 0.1 gram of heroin (enough for one injection) is about $80, which means a gram would be about $800.

If the law does not allow police to make telephone taps or undercover buys, how are they successful in drug control?

"The most important thing to us — and everybody else anywhere in the field — is the informant. We get very good information, although our system works in such a way that too often the information we receive is old. This shows in our statistics: our seizures are small compared with the amounts I think we have in the country."

Using informants

While there are no Helsinki locations where drugs are sold, the police know, and those involved know they know, there are bars and restaurants "where these people like to drink beer, meet with each other, and, of course, talk about drugs and deals. But, the deals don't take place there."

Even if a stranger here should run into a dealer, the dealer would be cautious about selling even a small amount.

"The traffickers do not trust each other, they cheat from time to time. No matter how much they shake hands, swearing if they are caught nothing will be said. It doesn't hold."

Finnish law is strict: under general law a suspect can be arrested and kept in custody for a maximum of 17 days.

"We have a long time, if you think internationally, to investigate a case without any involvement from the outside."

It may not be pleasant for the "clients," as Commissaris Turkama calls them, to be kept in custody for 17 days but, he says, "you won't find out there on the street clients who say, 'They (the police) are crooks, they are no good.' We achieve nothing by being mean.

Turkama: Finland's Maigret

"On the contrary, we like to be nice, offer them coffee, talk about the things they like to talk about — football, their family."

At the moment in Finland, there is vigorous debate about giving police the power to tap telephones in drug cases or especially violent criminal cases. Most of the media are opposed, although a parliamentary committee on the police has recommended the power be legislated.

Commissaris Turkama is of two minds. "Of course it would help us, because with tapping you would get genuine information, up to date, that doesn't cost very much compared to the time and manpower involved in following suspects.

Abuse of power

"On the other hand, what is quite correctly being brought up is the possibility of abuse of this power by policy makers.

"I try to look at this objectively, not only from my personal point of view as a policeman, but also as a Finnish citizen.

"I must point out that I think the biggest resource the police have is the trust of the public."

Commissaris Turkama is equally adamant about drug buys. "I don't want to start until we get proper permission and society understands it is good to do so."

The firestorm of cocaine use in the US is a crucial factor: "Finns travel today as much as people from any other nation, and I am afraid that movies, television, and books, as well, have made people curious about cocaine and that they will want to try it. It is an international phenomenon.

"It is going to come here, of course, but at the moment we have made only a few seizures, and they have been very small. It may exist in some circles, but I don't think it would be possible to make any sort of street buy here."

The Finnish concentration on demand control is essential. "Nobody in the world has succeeded in controlling supply. It is an international problem: we in Finland can't try to affect opium poppy growing in the Golden Triangle or coca bushes in Bolivia and Peru.

"But, demand is a domestic problem. If we affect public opinion on narcotics and the damage they can do to a person and society, then there is a good possibility we will succeed."

Drugs 'not for us'

Complacency is not on the agenda, as the commissaris' constant international contact illustrates.

But, there are hindrances: because Finland's major problem is alcohol and the drug problem is small compared with neighboring Sweden's, much less other countries, many wonder why the police might need additional powers.

Commissaris Turkama patiently explains the Finnish problem remains comparatively small only because the police and courts have kept on top of it since 1969, and there are vigorous programs concerned with demand reduction.

He sums up: "Finland is trying to make it clear that we as a society have decided drugs are not for us. We have forbidden them by law and because of this the police, as one of the control bodies, will make the law effective.

"We don't have to discuss it. Even in the US, they leave it to people to try drugs or not. The right attitude is to forbid; drugs are no good, they will harm you. You can never control your drug use, whether you are a doctor, or a schoolboy."

THE BACK PAGE

EAPs: reports from the North American congress
p4

Council of Europe leads on drug forfeiture
p7

A week in the life of the ARF
The centre section

Vol. 15 No. 10 2nd Class Mail Reg No. 2776 TORONTO, October 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Young girls stripped at prison drug check

KINGSTON — A mother and her three daughters, aged two, five, and 12 years, were strip-searched before being allowed into Collins Bay Penitentiary here for a family visit.

Nothing was found during the search, and the mother subsequently lodged a complaint with an independent federal investigator authorized under the federal Inquiries Act to investigate complaints about prisons.

The woman said she's been told by the investigator there were "reasonable grounds" for prison authorities to request the strip-search. But, she added, the investigator told her he can't reveal any details.

(See Mother, p2)

Leaping lizards latest drug loot

AUCKLAND, NZ — Police and wildlife experts say New Zealand's rare tuataras, lizard-like cousins of the long-dead dinosaur, are being used as payment in international narcotics deals.

The spiny-backed reptiles, which grow to two feet in length and weigh slightly more than two pounds, have become a hot collectors' item on the international black market. Police say they fetch nearly $8,400 each.

The only survivors of an order of reptiles that became extinct 60 to 80 million years ago, tuataras are found only on 28 small islands around the New Zealand coastline. The remoteness of their island homes makes them easy prey for poachers in boats or helicopters.

New Zealand's wildlife service estimates dozens have been smuggled out of the country in the past four years. United States authorities have told the service they believe tuatara trafficking is linked to narcotics trading, with the reptiles used as payment for drugs.

Tuatara: collector's item

The corner store debates

By Joan Hollobon

TORONTO — Two developments viewed as industry tactics to increase alcohol consumption by increasing availability and by appealing to youth are causing concern in several Canadian provinces.

The issues are the sale of alcoholic beverages in grocery and convenience stores, and the emergence of so-called 'citrus coolers' containing less than 1% alcohol.

Sarasoda, a "sparkling citrus cooler" made by a Labatt's Ltd subsidiary, Holiday Juice Ltd of Windsor, Ontario, has hotted up the debate on these products in recent months, somewhat to Labatt's surprise; other under 1% alcohol 'coolers' have been on sale for several years with very little public reaction.

Citrus coolers are an issue in five provinces: Ontario, Manitoba, Saskatchewan, British Columbia, and, to a minor extent, Alberta. The matter has not aroused controversy east of Ontario, or in the Territories.

Sarasoda was launched in Ontario in November, 1985, introduced to Manitoba last March, and to Alberta and Saskatchewan in early summer.

In addition to the citrus coolers are the under 1% shandies and beers, such as Swan's, an Australian 0.9% beer, a 0.4% Swiss "malt beverage" called *Birrel*, and a similar German product, *Gerstel Brau*, containing 0.5% alcohol.

Manufacturers claim the under 1% beverages are designed to provide adults with a low-alcohol alternative to regular strength alcoholic drinks; opponents fear the drinks may introduce children to alcohol, particularly through the citrus coolers.

The federal Health Protection Branch, Health and Welfare Canada, is considering both viewpoints in an evaluation of Sarasoda.

"Sarasoda is not a sweet drink," Dennis Manning, Labatt's director of public affairs, told The Journal.

He said development of the very low-alcohol drinks is in line with a general move to lighter beverages.

Mr Manning: "The whole population is moving toward lighter drinks, and we see the trend growing rapidly . . . . If you're drinking to acquire a mild sedation, then Sarasoda isn't going to fill the bill."

In Ontario, Monte Kwinter, minister of consumer and commercial relations, accepted recommendations by the Addiction Research Foundation here that: local communities exert

pressure on retailers if sale of the low-alcohol products results in problems for children or youth, governments ask manufacturers to insert in each carton a notice alerting retailers to the problem of use by children, and information be disseminated to parents and teachers.

Extending the sale of beer and wine to grocery or convenience stores also is far from being an issue of national concern.

In Ontario, the minority Liberal government plans legislation before year-end to permit such sales, but this is widely seen primarily as a move to fulfil an election promise. The bill's defeat is predicted since both opposition parties oppose the extension of alcohol sales.

In Alberta, a private member's motion proposing privatization of the sale of alcoholic beverages in rural communities of fewer than 1,000 inhabitants was debated in the legislature, but has dropped to the bottom of the order paper. Most likely, it is a dead issue since the health and social services committee of the government caucus is against the idea.

In all other provinces, distribution of alcohol beverages, particularly beer, presumably is already broad enough to satisfy most customers.

In Newfoundland, for example, beer has been sold in corner convenience stores — not grocery stores — in small communities for years. The practice was extended to convenience stores in St John's in 1980.

At the other side of Canada, hotels and motels in the Yukon can sell beer 24 hours a day, if they wish, under their off-premises licences. Liquor may only be sold by the bottle during the on-premises licence period, which currently can go to 2 am, but may be reduced.

Quebec has long had beer and wine available in grocery stores. It is taken so much for granted, in fact, that one informant could not remember without checking whether grocery stores could sell both.

The low-alcohol coolers have recently come onto the Quebec market also. They are selling well without any controversy.

Provincial regulations establishing the definition of what constitutes an alcoholic beverage requiring controlled sale are as varied as the provincial attitudes on both issues.

The actual percentages of alcohol that a product must contain before it finds itself confined to the shelves of government liquor stores not only range from 0.5% to 2.5% by volume, but also, even the methods of measuring the alcohol content vary (see page 2).

While most provinces measure alcohol by volume, Saskatchewan measures alcohol by weight. This requires calculation of the specific gravity of each product before the weight measurement can be translated accurately to a volume figure.

Manitoba's current legislation sets 2.5% proof spirit (equivalent to approximately 1.43% by volume) as the legal minimum. But, this is being changed in the current revision of the act to measurement by volume. The original intention

(See Debate, p2)

Are low-alcohol coolers a boon to sobriety, or a first signpost to children that alcohol is 'cool?'
The Back Page

Reagan

Mulroney

Addictions power base shifts in US

BOSTON — As Canadian addictions professionals watch Ottawa for follow-up to Prime Minister Brian Mulroney's new public concern about drugs, their United States peers are starting to play tough with President Ronald Reagan, from whom a great deal of concern has been heard.

When the president sent greetings, but not Carlton Turner, PhD, to the meeting here of the North American Congress on Alcohol and Drug Problems, 800 delegates snapped a telegram back: Thanks for the greetings, but no thanks for not sending our scheduled keynote speaker Dr Turner (chief adviser to the White House on drugs).

Observers say the delegates wouldn't have snapped a year ago; but a year ago there wasn't as much political heat on the issue.

"What is very difficult for me as a field professional is the contrast between the dedication of the president with the reality of what the administration has given in terms of direction and support," said William Hartigan, president of the US Alcohol and Drug Problems Association of North America.

INSIDE

NEWS

Briefly ...

Slick licks

LOUISVILLE, Kentucky — An internationally known maker of ice cream has introduced a new flavor to entice yuppie taste buds, says the *Pulsebeat* newsletter here. Baskin-Robbins' latest taste treat is called Gran Marnier and contains brandy and 1.7% alcohol.

Burned-out GP

LONDON — A general practitioner who helped set up an alcohol and other drug abuse distress centre has turned to abusing drugs himself. The doctor, who was fined £2,500 ($5,133 Cdn), obtained drugs by making out prescriptions in the names of patients, some of whom had recently died, says *Doctor*. The GP admitted three offences of dishonestly obtaining pethidine (eg, Demerol), possessing the drug, and failing to keep a record of controlled drugs.

Down Under ban

CANBERRA — The Australian government plans to ban smoking in all its offices nationwide within the next 18 months, says *Reuter*. While discussions are ongoing, the government is seeking an immediate stop to smoking in official meeting and training rooms and other specified areas.

Boats should float

TORONTO — Drunk boaters continue to capsize, run aground, or collide with other craft, despite a major crackdown by Ontario Provincial Police. Twenty-eight people died this past summer; the previous summer there were 21 deaths, says *The Toronto Star*. A spokesperson for the Muskoka Lakes Association said: "People who wouldn't think about drinking and driving in a car will still get in a boat. It would appear that when people go on holiday, they think drinking and boating go together. But, they don't."

On-the-job perk

TORONTO — A former Canadian Broadcasting Corporation (CBC) manager is performing 1,000 hours of community service after being convicted of financing his cocaine addiction with $40,000 in expense account padding. The judge who passed sentence, reports *The Globe and Mail*, suggested CBC colleagues share the blame because they knew the man was abusing drugs and did nothing. "Some may consider this to be contributory negligence," said Judge David Humphrey.

Applause to cause

OTTAWA — Canadian Health and Welfare Minister Jake Epp has praised *The Globe and Mail* for its decision to refuse future tobacco advertisements. Mr Epp told *Canadian Press*: "Obviously, I'm delighted at one of Canada's major newspapers taking its responsibilities very seriously." The Globe follows the *Kingston Whig-Standard* and the *Brockville Recorder and Times* in its new policy.

Sarasoda should be shelved: CMA

By Betty Lou Lee

WINNIPEG — Canadian doctors want low-alcohol 'soft drinks' out of retail stores and into government-controlled outlets.

They took particular aim at the Sarasoda brand, a citrus drink with 0.9% alcohol by volume, at the annual meeting here of the Canadian Medical Association (CMA). It's being marketed in several provinces and escapes government control because it has less than 1% alcohol (see page 1 and The Back Page).

The CMA wants all beverages with more than 0.5% alcohol covered by provincial liquor control board regulations. Although some doctors suggested 0% at the meeting here, they were told this was not realistic because de-alcoholized beers (sold in grocery stores) couldn't be reduced below 0.4%.

Victor Dirnfeld, MD, of Richmond, British Columbia, said he was "appalled and outraged that a soft drink company whose only motive is profit and greed can foist on our kids a 'soft drink' with alcohol in it."

(The manufacturer of Sarasoda, Holiday Juice Ltd, is a subsidiary of Labatt's Ltd.)

The CMA council on health care, which studied the issue, said it considered the views of Joan Marshman, PhD, the president of the Addiction Research Foundation, Toronto. She "suggested these products may be part of a marketing strategy by brewers or other distributors of alcoholic beverages to blur the distinction between alcohol products that may be sold over the counter without control and those which contain levels of alcohol that place them under control."

The council said the significant factor "is the uncontrolled distribution of an inexpensive beverage to potentially unprepared youth."

The CMA general council also voted in favor of lowering the legal limit for blood alcohol levels while driving to 0.05% from 0.08%.

The council on health care noted: "Data from the United States National Highway Traffic Safety Administration support this position, as does the American Medical Association. Further, the alcohol industry itself recommends this level as acceptable."

The CMA will also develop a "comprehensive policy" on substance abuse and driving.

Stephen Hart, MD, chairman of the New Brunswick Medical Society's committee on preventable aspects of motor vehicle death and injury, said backing tougher laws wasn't enough.

"Our obvious failure to effectively change behavior as it relates to alcohol, (other) drugs, and driving is best explained by our lack of understanding of this complex problem. For too long, we have looked to tougher laws as the only solution, and tough laws have failed to provide desired results. It's easy to pass laws; it's harder to bring about social change.

"And, of course, another policy statement from the CMA will not go far to solve the problems of substance abuse and driving unless it outlines well-researched objectives and a plan of action for achieving them."

New 'soft-drinks' will/won't hurt kids

Debate is two-sided on low-alcohol coolers

(from page 1)

was to reduce the limit to 1%; following a submission by the Manitoba Medical Association (MMA), the limit was further reduced during committee stage to 0.5%.

This section, however, will not go into force when the bill receives royal assent at the end of the current session. It will be proclaimed separately later, unless it is again amended by further review. In the meantime, the present 1.43% will remain in force.

As a result of the MMA's concern about under 1% drinks, the Canadian Medical Association at its August annual general meeting in Winnipeg recommended all provincial governments reduce the percentage to 0.5% (see story above).

"We have enough problems with alcohol without introducing it in such an almost surreptitious way," Normand DaSylva, MD, told **The Journal**. Dr DaSylva is the CMA's director of health services.

"There's no reason why soft drinks should be laced with alcohol, if only because children should not get accustomed to using alcohol, even if they do not feel any effect from it. We think they would, however," Dr DaSylva said.

Mr Manning said alcohol is added to improve the taste.

At present, there are no under 1% beers made in Canada because the taste achievable at that low level is not considered acceptable by Canadian breweries.

"We went through a long period of experimentation with Select (2.3% alcohol) to get a true beer taste," Mr Manning said.

The brewery also produces Twist shandy at 2.3%. These products currently compete in the cooler market, not the beer market. The dedicated beer drinker remains somewhat suspicious even of the 4% beers, although these are catching on now "at quite a dramatic rate. . . . In Saskatchewan, Labatt Light is competing head-to-head now with a full 5% beer."

In Ontario, between 1974 and 1984, total beer sales rose by 9.3%. However, population increases and a gradual move to lower-alcohol products resulted in a 6.3% reduction in the adult per capita consumption in the decade, Mr Manning said.

National roundup

BC	Alta	Sask	Man	Ont	Que	NB	NS	PEI	Nfld	Yukon	NWT
Alcohol levels (by volume) requiring government control											
1%	1.5%	1.31% alc by weight = approx. 1.46% by volume (1)	2.5% proof spirit = approx. 1.43% by volume (2)	1%	.5% (3)	0% (4)	.5%	.5%	1% (5)	2.5% (6)	1%
Sarasoda — under 1% beverages — An issue?											
Yes	Minor Concern	Yes	Yes	Yes	No	No	No	No	No	No	No
Beer and wine in corner stores — An issue?											
No	Yes	No	No	Yes	No	No	No	No	No	No	No

(1) **Saskatchewan:** The statute first passed in 1925 establishes a measure of 1.31% alcohol by weight, which converts approximately to 1.46% by volume. Accurate measure on any individual product requires calculation of that product's specific gravity.

(2) **Manitoba:** Legislation under revision. New legal minimum will be 0.5% by volume. This section will not come into force when the new Act receives Royal Assent, but will be proclaimed separately later. Until then, the present limit will remain in force.

(3) **Quebec:** The government legally controls all beverages containing more than 0.5%, but this does not require the products to be sold only through government outlets. Beer and wine are widely available in grocery stores.

(4) **New Brunswick:** The government legally controls beverages containing any alcohol, although an exception is made for "non-alcoholic" beverages with 0.1% alcohol. Beer is defined as having not less than 2% alcohol, so low-alcohol "beer" is legally not beer.

(5) **Newfoundland:** Changed to 1% from 3% in December, 1985.

(6) **Yukon:** Legislation under revision. The present level of 2.5% will probably be reduced to 1.1%, but might be reduced further, or the legislation might give the Yukon Liquor Corporation discretion to control beverages with lower levels than the statutory limit if deemed necessary. The revised law is expected to be in force before year-end.

— coming up in —

THE JOURNAL

• Reports from the US National Federation of Parents

Mother seeks legal aid to battle prison search rule used on kids

(from page 1)

The woman is not satisfied with these statements and has applied for legal aid to help finance a court challenge against prison searches.

"I feel it shouldn't happen to any child under the age of 16 years. It's hard enough with the father being in there, let alone having to go through this," she told **The Journal**.

"I have a 12-year-old going through puberty, and she won't even change in front of me. She hasn't seen her father since."

Prison officials are given authority to conduct a strip-search when a visitor is suspected of carrying drugs into an institution.

During 1985, there were 84 strip-searches at Collins Bay, representing only a small proportion of the 25,000 to 30,000 visits at the medium-security institution each year.

Correctional Service Canada spokesman Dennis Curtis said none of the 84 searches resulted in contraband being found. However, he said many other visitors asked to undergo a strip-search declined and instead left the prison.

The incident occurred at the prison on August 23. The family was strip-searched by female prison guards prior to visiting the children's father, who is serving a seven-year sentence.

NEWS

Judge criticizes random checks on inmates

Quebec court decision ends prison urine tests

By Anne Kershaw

KINGSTON — Urine testing of inmates for drugs has been halted at three Canadian federal prisons after a Quebec judge ruled that the program violates the Charter of Rights and Freedoms.

Mr Justice Louis-Philippe Galipeau of the Quebee Superior Court said that while he recognizes the need for officials to "take steps to put an end to the evil generated by the presence of intoxieants in prisons," some aspects of the program were too arbitrary to comply with principles of fundamental justice.

The tests have been discontinued at the medium-seeurity prison in Joyceville, Ontario, where the program had been in effect for the past 10 months, and the Prison for Women in Kingston, where the tests began a few months ago (**The Journal**, June).

The drug program never actually got off the ground at Quebec's Cowansville Institution, where the legal challenge to urinalysis testing originated with inmate Jean-Pierre Dion on behalf of 243 fellow prisoners.

The court ruling is a setback for prison officials faced with the task of curtailing drug use inside the prison walls.

Dennis Curtis, a spokesman for Correctional Service Canada here, says the service had hoped to expand urinalysis to all major institutions in Canada within two years.

Mr Curtis says the government will either appeal the ruling or modify the program to remove those aspects which violate prisoners' rights as determined by the court ruling.

One aspect of the program that drew criticism from Judge Galipeau was the use of random testing of inmates as well as tests for those under suspieion of carrying drugs.

The tests have been used mainly as a deterrent to stop the flow of drugs into the prisons from visitors and from inmates returning from day passes (see page 1).

Inside view: officials face flow of drugs from outside

New drug research centres called for by MDs

By Betty Lou Lee

WINNIPEG — Research centres to study opiate dependency and treatment should be established in Canada, the Canadian Medical Association (CMA) recommends.

The CMA says that existing facilities, such as the Addiction Research Foundation in Ontario and the University of British Columbia, Vancouver, be considered as bases for the development of such centres, which would also provide clinical services.

A steering committee chaired by William Ghent, MD, of Kingston, has been studying the issue since last year and concludes that Canada lacks both research and treatment facilities.

Andrew Young, MD, of Chilliwack, BC, chairman of the CMA council on health care, told the annual meeting here there are only 13 drug addiction clinics in Canada to serve an estimated 250,000 to 500,000 addicts.

The steering committee identified seven impediments to research: lifestyles and variance of compliance in the patient population, multiple drug use, difficulty in distinguishing psychological from physical aspects, irregular regional distribution of patients and treatment facilities, negative attitudes by the medical profession, difficulty in coordinating services provided by multiple care-givers, and lack of accurate information on the number of drug-dependent people, treatment facilities, and praetitioners involved.

The committee listed 11 research issues which should be given priority and which could improve the quality of future research.

They include: eommon definitions for terms like drug dependency, cure, and success; documentation of the natural history of the disease, including the long-term effects of opiates; identification of the differences between those who seek treatment and those who don't; development of criteria for assessment of patients; and, identification of potential risk factors of dependency.

A computerized profile of the drug-dependent person, including age, sex, religion, social class, retrospective history, and medical and recreational use of drugs, is another priority issue.

Others are: identifying the psycho-social, legal, and ethical aspects of treatment and the role of the medical profession; finding objective measurements for methadone dosage schedules in maintenance programs; doing longitudinal studies of subgroups like teenagers or medical students; and, developing an outcome assessment system for different treatments.

It's a combination of factors

US studies 'longest decline' in alcohol use

WASHINGTON — There is probably no single factor involved in the decline of alcohol consumption in the United States — which started in 1981 and has been the longest decline since prohibition — says Loren Archer, acting director of the US National Institute on Alcohol Abuse and Alcoholism (NIAAA).

"There are those who from their own research bias will argue for economics, or education, or parental activities. But from what we see, it is no single factor but a combination of factors," Mr Archer told the 1st National Conference on Alcohol and Drug Abuse Prevention sponsored here by NIAAA and the National Institute on Drug Abuse.

Citizens have become more involved in alcohol-related problems, from those who discourage drinking and driving to those who discourage drinking with slogans such as "Say no to alcohol" and "Be smart. Don't start."

Many US localities have put restrictions on happy hours, and there has been a big increase in server training and education.

Mr Archer took aim at the phrase "responsible use," saying there is no responsible use of a drug now illegal for those under the age of 21 years, which alcohol is in US states that raised their drinking age. And, there is no responsible use for recovering alcoholics, pregnant women, or nursing mothers.

Mr Archer: "Unfortunately, responsible implies a positive aspect, and what we forget is that we are dealing with a drug — the number one drug of abuse and addiction, the number one drug causing the major proportion of deaths across the nation."

INSIDE OUT

It's the thought . . . I think

The other day I was reading — I forget where — that heavy smokers risk an earlier onset of Alzheimer's disease than other people.

So I'd better put my thoughts down quickly, before each of them vanishes inevitably in a puff of smoke from my memory database system.

Not that these thoughts will be coherent or pretty, you understand.

I have decided — so enormous is my guilt — to write them without benefit of a cigarette, or nine of them. And, for writers who smoke a lot, this is the equivalent of a diver working in a pool with no water. My mind, I have found, seems to tend to lack any weight, any scnse of focus, when I don't smoke as I write. The appropriate adjectives fly out the window of the brain when I look to capture them; I suddenly forget all the proper verb tenses; nouns appear to melt as I shakily hold them up to the light.

Somebody said recently — of course, I don't remember now just who it was — that the final civil war will be between smokers and non-smokers.

I've come to believe it.

In certain neighborhoods of modern life, smokers are beginning to be looked upon with the pity mixed with scorn that winos are used to getting all the time, as they loll and weave in downtown doorways. We who smoke are being pushed at an accelerated rate into that same doorway; we've become an endangered species, and many endangered species often fight on irrationally, right to the end.

Yes, we really are a dying breed, if you want to put it that way. ('Smokers, a dying breed' — a nice phrase, don't you think, for the anti-smoking lobby's next billboard campaign? Just send the cheque here to me at **The Journal**.)

While, naturally, all the ammunition is stacked up high in the non-smokers' camp; just try to convince anyone these days that smoking has even one minor blessing attached to it. I suspect the war will be protracted, bitter, and bloody. Even if various governments — will there come a time when there are smoking and non-smoking countries? — finally ban tobacco production altogether, there will continue to be pockets of guerrilla smokers hiding out in the countryside, nurturing their own home-grown produce clandestinely, and talking irrationally and ever more shrilly and loudly about how they are protecting and preserving individual freedoms. Fools are most stubborn when they're being most foolish.

'Mommy, doesn't that man know smoking is bad?'

No, it isn't fun being a pariah, I can tell you. The other day, I forget which one naturally, I was on a train in the smoking section opposite the snack bar. Not one, but two small children, a few minutes apart from each other in the line-up, looked at me as I sat reading and minding my business, and they pointed at my lighted cigarette and said, not in a whisper, something like: 'Mommy, why is that man smoking? Doesn't he know it's bad?'

What was I supposed to do? Tell them to shut up? That it wasn't their affair? That smoking is still legal? Of course, I did none of the above: that's how heavily mired in shame smokers are these days.

It's a shame I've had to carry for years, in some ways even more of a shame sometimes than that of being a progressively heavier drinker, before I lurched over the line into alcoholism. I have notebooks, written during the white heat of post-adolescence, 20 years ago, full of self-penned exhortations to quit smoking. Over and over again in the notebooks, there it is: 'Stop smoking tomorrow!' The exhortations went on for two years, until I got over my addiction to notebooks and writing in them.

Now, you would think that a human being giving up one addiction — in my case, it's booze — would naturally make it easier to give up another one, like smoking. That's what I thought, anyway, once I began to get a handle on alcohol. But what has constantly surprised me, now that I've been exposed to the brotherhood of alcoholics, is how many of us keep right on smoking our brains out.

If many of us were forced to stop drinking because our lives were in serious peril, then why can't we find the same extinguisher to put out the smoker's fire?

Is it that since we have 'conquered' one monkey, we somehow believe we have a right to continue to indulge in another one, even though we know it's just as bad, often, as the one we let fall by the wayside? Aren't the same mechanisms at work in each addiction — the same prolonged denial of reality, of the facts, of the inevitable end if we continue to gorge ourselves?

Why, when each of us has been through the humbling, liberating process of going for help to stop drinking at various clinics and rehabilitation centres, didn't 'they' also try to get us to quit smoking at the same time?

Do most of us only have enough energy and will to give up one major addiction in our lifetimes? Is the effort required for shrugging off the one heroic enough to avoid giving serious attention to another? Is smoking the only reward left to recovering alcoholics? Do we deserve to coddle ourselves with it?

What is the point of remaining sober if we are, perhaps, killing ourselves with tobacco?

I wish I knew the answers to these questions.

Somebody once said that smokers aren't very bright people, when you get right down to it.

But I can't remember just now who that somebody was. Maybe it was me.

This column, exploring addictions from the "inside out," is by a freelance Canadian journalist.

EAP NEWS

RESEARCH UPDATE

THC and luteinizing hormone levels

There is now direct evidence that smoking marijuana has an immediate impact on one female reproductive hormone. Researchers from the Alcohol and Drug Abuse Research Center, Harvard Medical School/McLean Hospital, Belmont, Massachusetts, studied the impact of smoking marijuana on 16 healthy, women volunteers with normal menstrual cycles, who were not using birth control medication. Each subject was tested twice, once after smoking a one-gram marijuana cigarette containing 1.8% delta-nine-tetrahydrocannabinol (THC) and once after a placebo cigarette. Blood samples were taken at regular intervals for three hours to measure any changes in plasma hormone levels. Results show that from one to two hours after smoking, marijuana significantly suppressed luteinizing hormone (LH) levels, compared with placebo, during the luteal phase of the menstrual cycle by about 30%. During the follicular phase of the cycle, LH levels were not significantly affected. Estradiol and progesterone, two other reproductive hormones, were not affected by marijuana at any time of the cycle. The researchers say their findings corroborate animal studies and suggest the shortened luteal phase duration previously observed with women marijuana smokers may be associated with the marijuana-induced suppression of LH during that cycle phase. Further studies of the impact of marijuana on hormonal and reproductive function in women are needed, they conclude, especially given other experimental data which indicate marijuana-induced derangements in fetal growth and development.

The Journal of Pharmacology and Experimental Therapeutics, June, 1986, v.237:862-865.

Improved alcoholism diagnosis

Simple clinical measures can provide a more accurate diagnosis of alcohol abuse than laboratory tests, says an exhaustive study. Three scientists from the Addiction Research Foundation, Toronto, and the chief of the gastroenterology division of the Southern Illinois University School of Medicine, Springfield, looked at 108 clinical and laboratory tests identified as potential indicators of alcohol abuse. These tests were used to examine 314 subjects from three different groups: outpatients with alcohol problems, social drinkers, and patients from family practices who did not report excessive drinking. Statistical analysis showed clinical signs had an overall accuracy rate of 85% to 91% for detecting alcohol abuse, compared with 84% to 88% for items from medical histories, and 71% to 83% for laboratory tests. Among the most valuable clinical indicators of heavy drinking were a reduced peak expiratory flow rate, increased diastolic blood pressure, and the presence of several neurological findings and signs of liver disease. Indications of alcohol withdrawal symptoms, anxiety, and depression proved to be valuable medical history items for differentiating the groups, while laboratory measures of gamma-glutamyl-transferase and mean corpuscular volume were found to significantly differentiate those suffering from alcohol abuse from the other two groups. The investigators found the probability of alcohol abuse exceeded 90% when four or more clinical signs or medical history items from an index of 17 clinical signs and 13 medical history items were present. They say significant inroads into identifying drinking problems could be made if clinicians administered this alcohol clinical index routinely during clinical examination and corroborated it by a brief questionnaire on alcohol problems as well as use of the two laboratory tests.

British Medical Journal, June 28, 1986, v.292:1703-1708.

For those who can't quit

New evidence suggests that "smoking air," that is, ultralow-yield cigarettes, confers some benefits to smokers but does not deliver the favorable tar-to-nicotine ratios predicted by smoking machines. The study by researchers from the clinical pharmacology unit at the San Francisco General Hospital Medical Center involved two different evaluations of habitual smokers. In the first study, 22 volunteers smoked high- (15 milligrams of tar), low- (5 mg of tar), or ultralow-yield (1 mg of tar) cigarettes. Concentrations of tar, nicotine, and carbon monoxide exposure were measured. No differences in exposure were seen for the high- or low-yield cigarettes, but tar exposure (as reflected by the mutagenic activity of the subjects' urine) and nicotine exposures were reduced by 49% and 56% respectively, and carbon monoxide exposure was reduced by 36% when the ultralow-yield cigarettes were smoked. Thus, the subjects were able to consume as much nicotine, carbon monoxide, and tar from the low-yield cigarettes as from the high-yield ones. However, they were not able to compensate for the much lower yields of ultralow-yield cigarettes which they rated as very poor in quality and similar to "smoking air." In the second evaluation, 248 subjects were compared after smoking their usual brand of cigarettes. Nicotine intake was estimated to be 40% lower in those smoking ultralow-yield cigarettes. The researchers say the public should be informed that while ultralow-yield cigarettes are not "tar free," exposure to tar, nicotine, and carbon monoxide is substantially reduced when a smoker switches to this type of product. It is uncertain whether such a reduction gives any protection from development of smoking-related diseases, but the researchers conclude it is reasonable to encourage smokers who cannot quit to switch to ultralow-yield cigarettes.

Journal of the American Medical Association, July 11, 1986, v.256:241-246.

Pat Rich

Addicts' needs are same as other convalescents'

Recovery is 'tempestuous'

By Terri Etherington

TORONTO — Employee assistance programs (EAPs) should treat recovering alcohol- and other drug-dependent patients in the same way they treat workers convalescing from other illnesses, says Douglas Macdonald, MD.

Dr Macdonald told the North American Congress here on EAPs recovering employees are no different from, say, heart attack patients.

"If I said to you, 'This patient was in the hospital for the last six weeks with a heart attack, but is fine now,' you would do these things to help him along his way: let him go early in the day, take time off to see a doctor, etc.

"All those things should be done for the alcohol and polydrug-dependent patient coming back to work.

"I want you to say that this patient is convalescent and will be convalescent for at least two years, and something has to be done to help," said Dr Macdonald, president and executive officer, Oxford Institute, a chemical dependency treatment centre, in Oxford, Michigan.

Dr Macdonald said EAPs should make it clear to the recovering worker that he or she will be working with the EAP for at least one year in follow-up. Recovery takes two to five years.

The patient and EAP workers also need to understand that the period of recovery "is a tempestuous time, riddled with psychosomatic disorders, stressful events, and poor ability to cope.

"It is a terrifying time for the patient because of his reduced capacity," explained Dr Macdonald, a former director of the Donwood Institute here.

Congress logo

But, he added: "There is more to a recovery program than simply one-on-one with your therapist once a week. There is more to a program than simply going to an AA (Alcoholics Anonymous) meeting once or twice a week."

Additional emphasis should be placed on repairing the physical health of the recovering employee.

"It is one of the areas we never stress. And yet, nonetheless, it is an important area in which to develop stress coping ability.

"We work hard with the marriage, with the family, with the job, with the therapist, and with the drinking, but we don't pay enough attention to the physical recovery of the patient."

It doesn't have to be a major program of running, jogging, and weightlifting. "All it means is modest exercise, attention to nutrition, and continued classes in stress management.

"If the patient comes up with four hours a day and nothing to do after he leaves the plant, he is right back out there where it all happened before, and he has nothing to fill his time."

Dr Macdonald told EAP workers what to expect in employees returning after acute care and withdrawal: compromised physical condition, reduced mental capacity, and impaired emotional stability.

This is confounded by fear, guilt, shame, and stigma. The social support network is in disrepair, often with loss of the feeling of belonging. The job is threatened or gone, there is often spiritual turmoil, and the overall coping ability is markedly reduced.

The EAP goal should be "to interrupt and inactivate the dependence, to repair all related damage, and to provide a treatment and recovery plan that will improve the patient's health status overall."

Macdonald: time

Corneil: backlash

Reynolds: victims

Canadian/US EAPs differ

By Mark Kearney

TORONTO — Anyone coming from the United States to market an employee assistance program (EAP) in Canada should leave their preconceptions at the border, says a Canadian EAP expert.

Wayne Corneil, national adviser on EAPs to the federal government, says the success of an EAP in Canada depends partly on recognizing the differences between the two countries and the "subtle differences" within regions of Canada.

"Some people try to sell EAPs here based on the US model, and it doesn't work," Mr Corneil told the North American Congress on Employee Assistance Programs here.

"EAPs in Canada are sold on the basis of how it will help the employees, not the employer. It's a more humanistic approach."

The US model developed out of private enterprise and a desire to give companies the best, cost-effective EAP, Mr Corneil said.

The Canadian experience, on the other hand, was firmly rooted in the public sector. EAPs evolved out of publicly funded Canadian addiction foundations that used consultants who didn't have to be as concerned with profit, he added.

There has been an increase in the number of private EAP consultants in Canada, Mr Corneil said. However, he suggested they keep in mind that the goal of most employers here is "to have a healthy workforce," not save money.

"That's not to say you can't make a profit, but if you emphasize that too much, you'll get a backlash from corporations, workers, and people in the EAP field," Mr Corneil warned.

"Don't get greedy, or you'll be the one who gets cut off."

He also advised those in the EAP field to remember: more than 50% of the Canadian workforce is made up of women, 40% is unionized, and treatment services available for employees vary widely from region to region in Canada.

All of these factors can shape the nature of the EAP a Canadian company provides, Mr Corneil said.

Sexually abused echo alcoholic family woes

TORONTO — Families in which violence or sexual abuse is common are often similar to those plagued by alcohol problems.

"The incest family and the alcohol-abuse family are similar," said Lynn Reynolds, PhD, co-director of the Institute Against Social Violence, Briarcliff Manor, New York.

They "don't talk, don't feel, don't trust. Secrecy is important."

In a majority of cases, family members who commit incest also abuse alcohol or other drugs, she told the North American Congress on Employee Assistance Programs (EAPs) here.

About 60% of her clients who were victims of incest or childhood rape are children of alcoholics (**The Journal**, May, 1985), and many grew up to marry alcoholics.

It's important that EAP counsellors be aware of this link; someone whose job performance is being affected by alcohol may also have underlying sexual and family problems from the past or present, Dr Reynolds added.

There are other similarities between victims of sexual abuse and alcohol abuse.

Both incest and heavy drinking are responses to stress, she said. The families involved tend to be isolated and to minimize the problem by calling it something else.

Someone who experienced incest as a child often develops feelings of inadequacy, lacks self esteem and the capacity for intimacy, and has little or no sense of accomplishment.

Dr Reynolds said while the form of abuse may be a little different, the fact of abuse manifests itself in people through "very much the same kinds of characteristics. I don't find there's too much difference."

NEWS AND COMMENT

Sell tobacco in no-frills wrappers, urge doctors

By Betty Lou Lee

WINNIPEG — Canadian doctors want all tobacco products sold in the equivalent of plain brown wrappers. And, there should be a standard package for each form of tobacco, such as cigarettes, cigars, and snuff.

The only printing on the package would be the brand name and in letters of equal size the message, 'This product is injurious to your health.'

Gerry Karr, MD, of Vancouver, who introduced such a resolution at the annual meeting of the Canadian Medical Association (CMA) general council here, said tobacco is the most expensive and preventable public health problem in Canada.

"We can't prevent its sale at this time, but we can minimize the extent to which manufacturers can make it attractive and maximize the danger."

Such a recommendation will be sent to the federal government.

Continuing to practise what they preach, council members voted to ban smoking at all CMA social functions. (They banned it at business and scientific sessions years ago.)

When one doctor wondered how husbands could control their wives' smoking, another retorted, "We've already told our patients and staff, it's time we told our spouses and families."

Another pointed out: "In the interests of moderation, the resolution doesn't include alcohol and sex." Someone else suggested postponing the toast to the Queen until the end of a meal.

(Etiquette demands smokers light up only after the toast, which traditionally comes at the beginning of the meal.)

The ban had limited immediate effects. Smokers continued to puff at an open-air barbecue the same night. The next night, at the presidential dinner and ball, some smokers went into the hallway to indulge. At one table, however, three men were simultaneously smoking cigars.

In another move to protect people from second-hand smoke, the general council took the view that regulations should be developed to provide workplace protection consistent with the protection provided against other hazardous substances.

Stringent drug enforcement would help

Health Protection lambasted

WINNIPEG — Addiction to prescription drugs is a major disease in Canada, and there should be more stringent enforcement of federal laws to combat it, says the Canadian Medical Association (CMA).

"The Health Protection Branch (of Health and Welfare Canada) is not doing a good job," Roy leRiche, MD, of Edmonton, told the annual meeting of the CMA general council here.

"They're afraid of their own shadows, afraid of being taken to court if they try to bring doctors and pushers to account."

He said introduction of a triple-pad prescription system in Alberta for the most widely abused drugs has brought "horrible revelations.

"In Edmonton alone, 400 are chemically addicted or have a major role in pushing. One man was able to get 2,800 Demerols (pethidine), which he could sell on the street for $10 each, from various doctors over two months.

"It's strange that the RCMP (Royal Canadian Mounted Police) and the local police are as aware of this as we are."

GILBERT

Vitamins and popular drugs: I

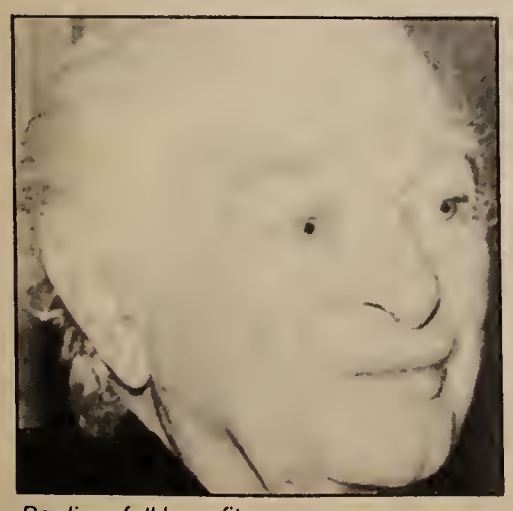
The cherubic face of 86-year-old Linus Pauling smiles from the cover, appealing testimony to his claim that regular use of "megadoses" of vitamins adds years to your life. The book, *How to Live Longer and Feel Better*, published this year by W. H. Freeman and Co, is currently gracing the display cases of bookstores across North America.

Dr Pauling's previous books, *Vitamin C and the Common Cold* (1970) and *Cancer and Vitamin C* (1979, with Ewan Cameron), aroused popular awareness about the importance of the substance known chemically as ascorbic acid, for the occurrence of a wide range of bodily functions. The books made a powerful case, still not accepted by many reputable authorities, for the regular consumption of *grams* of vitamin C each day rather than the tens of milligrams (mg) considered necessary by, for example, the Food and Nutrition Board of the United States National Academy of Sciences and the US National Research Council, or the 150 mg per day recommended by Health and Welfare Canada.

Childhood hero

I was more impressed by Dr Pauling's arguments than by those of the opposition. I had been impressed by Linus Pauling since my high school days and the award to him of the 1954 Nobel Prize for Chemistry. His classic, *The Nature of the Chemical Bond*, was the only understandable book we were given to read on the fundamentals of chemistry — and it was a seminal work, not a textbook. At the same time, Dr Pauling was in the news as a leader of campaigns against nuclear weapons and later as recipient of the Nobel Prize for Peace, all of which endeared him more to young iconoclasts.

A vitamin is an organic dietary constituent necessary for life, that does not function by supplying energy. A substance can be a vitamin for one species and not for another. Ascorbic acid,.for example, is a vitamin (vitamin C) for humans, other primates, and guinea pigs, but not for other mammals, who manufacture it in their livers.



Pauling: full benefits

Vitamins usually act as coenzymes, substances necessary to make enzymes work. Enzymes are catalysts for chemical reactions in the body. The enzyme sucrase, for example, found in the intestine, converts sucrose (table sugar) into the more digestible fructose and glucose. There are tens of thousands of different kinds of enzymes in the human body. Ingested coenzymes combine with apoenzymes (passive enzymes) produced by the body to form active enzymes.

Dr Pauling's new book extends his case for regular use of large doses of vitamin C to many vitamins, although he spends most time on vitamin C, which he describes as "the most important substance in the world." I am not going to attempt to evaluate his arguments, which seem persuasive to the non-specialist. Rather, I'll make the observation that a shortcoming of Dr Pauling's new book is its slight attention to the interactions between vitamins and popular drugs — caffeine, alcohol, and nicotine. In this column and the next, I shall expand on the little he wrote, drawing on current research in the area.

This month, I'll focus on vitamin C; next month, I'll deal with other vitamins and how they interact with popular drugs.

Here is a quick list of what Dr Pauling says are some of the benefits of consuming the 1,000 mg to 18,000 mg of ascorbic acid daily he recommends rather than the 60 mg to 150 mg recommended by dietary authorities:

- Wounds heal much more quickly because collagen synthesis depends on ascorbic acid.
- Production and motility of disease-combatting leucocytes are facilitated.
- Formation of polyps, tumors, and cancers is retarded as a result of oxidation of poisonous substances.
- Bowels are loosened and thus poisonous fecal material stays in the body for shorter periods.
- In people suffering from too much blood cholesterol, beneficial high-density lipoprotein levels are increased while harmful low-density lipoprotein levels are reduced.
- Stress is handled better because stress-induced deplctions of ascorbic acid from the adrenal glands are quickly compensated for.

Dr Pauling argues that taking 60 mg of ascorbic acid per day is enough to prevent scurvy, but very much more is needed to achieve the full benefit of the vitamin. In support of his argument that the optimum daily doses amount to thousands rather than tens of milligrams, he offers the following:

- Gorillas, other primates, and guinea pigs, all of which also require dietary vitamin C, consume the human equivalent of 1,750 mg to 4,500 mg per day. Indeed, commercial diets for experimental primates provide the equivalent of 1,750 mg to 3,500 mg per day.
- Humans living on a vegetable diet ingest about 2,300 mg of ascorbic acid per day.

. . . As with smoking, ascorbic acid levels are depleted by alcohol consumption even though the vitamin may help the body combat the disease-producing effects of abuse

- Rats manufacture the equivalent of 1,800 mg to 4,100 mg of ascorbic acid per day in their liver cells. Other species manufacture the equivalent of as much as 10,000 mg per day.

Dr Pauling himself takes 18,000 mg of vitamin C each day, more in times of illness and stress.

Who takes extra vitamins? A recent Finnish study shows users of non-prescribed vitamin supplements tend to have higher education than average and metropolitan residency. They also report more psychiatric symptoms. A British study shows intake of vitamins is lower among lower classes, particularly among smokers.

Vitamins and drugs interact in a variety of ways. They can modify each other's effects and the way in which the other is handled by the body.

Vitamin C and smoking

Perhaps the best-known interaction between vitamin C and consumption of a drug concerns smoking. Smokers tend to have more active livers than non-smokers and a higher metabolic turnover of many substances, including other drugs and ascorbic acid. The result is deplction of bodily levels of the vitamin.

Numerous studies have shown smokers tend to have lower blood and urine levels of ascorbic acid, other things being equal. Each cigarette, says one researchcr, destroys 25 mg of vitamin C. Even sceptics of the value of extra ascorbic acid agree smokers should take more, although sceptics say 40 mg more per day is probably enough.

The question arises as to what extent some of the ills of smoking are the result of anascorbemia, ascorbic acid deficiency. A reasonable answer is that compensatory doses of ascorbic acid likely reduce the damage smoking does to the skin and enhance the smoker's ability to combat disease. Whcther megadoses help further seems a moot point. Dr Pauling mentions undocumented reports of regression of bladder cancers in smokers who consume 1,000 mg or more of ascorbic acid a day. A study involving mice shows experimentally induced bladder tumors could be prevented by addition of ascorbic acid to drinking water.

Vitamin C and alcohol

Interactions between ascorbic acid use and alcohol consumption and its effects are less well-known, even though they are currently a more active area of research.

Alcohol use also appears to deplete vitamin C levels by causing increased rates of excretion in urine. In one recent study, the equivalent of three drinks of alcohol given to human subjects at breakfast depleted plasma ascorbic acid levels for 24 hours. In another study, guinea pigs given 30% of their total caloric intake in the form of infused ethanol were found to have lower levels of ascorbic acid in liver, kidneys, and adrenals compared with controls, no matter what the dietary level of the vitamin.

In the second study, the ethanol-treated group receiving low levels of ascorbic acid in diet developed fatty metamorphosis or steatosis of liver cells. The authors conclude: "Supplemental vitamin C ingestion may afford protection against ethanol toxicity."

Five recent studies involving mice and guinea pigs have produced the following conclusions:

- A diet high in ascorbic acid rcduces blood-alcohol levels in guinea pigs after acute and chronic ethanol administration, facilitates weight gain during chronic administration, and protects liver cells against steatosis.
- Single large doses (1,000 mg per kilogram) of ascorbic acid given to mice enhance their ability to remain on a metre stick while under the influence of alcohol. They also delay thc sleep-causing effects of alcohol, but extend the duration of the sleep.
- Preference for alcohol is not affected by ascorbic acid deficiency in guinea pigs, even under stress.

A rcasonable conclusion from current work is that, as with smoking, ascorbic acid levels arc depleted by alcohol consumption even though the vitamin may help the body combat the disease-produeing effects of abuse. In addition, vitamin C may counter short-term toxic effects of alcohol.

Caffeine and vitamin C appear to interact little, although rescarch on this matter is sparsc.

By Richard Gilbert

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

TJ deserves much wider market, says reader

I rarely write letters as a "fan," but this one is a combination of different sorts:

I enclose $24 for a subseription to be sent to your 387th foreign recipient, my brother-in-law, a "shrink" in Israel.

Your articles are not just informative, but superbly written . . . or should I say edited? Almost anyone could read, understand, and appreciate the information and messages from the world over. I rarely find something too technical that would require knowledge obtained only at university level.

I'm sure not only professional people are your subscribers, but you should also try to encourage every recipient to be a salesman (person) for you.

One suggestion is to allow yourself a bit more space for your own advertisement on subscriptions. I receive the *Jerusalem Post* regularly, and every issue includes a space that begins with a pitch of some kind, corny, light, or serious, that always winds up with the invitation to obtain subscriptions.

We have a radio station in Toronto on which the narrator compliments some aspect of Toronto, with the final line, "The home of our station."

Possibly, the Yardley Jones' cartoon of the month could be reproduced in a smaller size, with comments encouraging subscriptions.

Also, when a subscription is sent out like the one I just ordered, as a gift, you eould include an insert noting the donor's name and, if asked, the occasion.

I feel the emphasis on increasing your subscriptions should be directed primarily to non-professionals. After reading only a few concurrent issues of **The Journal**, I can see the continuity.

Boris Mirsky
Downsview, Ontario
(Ed note: Thank you for the encouragement. We'll pass your ideas on to our marketing department.)

Penitentiary examines drug abuse

Please send crime stats

We of the Saskatchewan Penitentiary read your publication with great interest.

Currently, we are in the process of setting up programs for sex offenders and other violence-related offenders.

Though we believe alcohol and other drug abuse plays a major role in these types of offences, we are having a hard time obtaining statistical data pertaining to these matters.

If you or any of your readers have any statistics on alcohol and (or) other drug abuse and its direct or indirect relationship to crime, we would very much appreciate hearing from you.

Keep up the good work.

Elmer Hicks
Alcohol and Drug Counsellor
Saskatchewan Penitentiary
Prince Albert
Saskatchewan

Readers back report on AIDS/marijuana link

Bruce McCubbin (July) appears to be saying, in regard to the marijuana-AIDS (acquired immune deficiency syndrome) link risk, that there are only two points of view: namely, his and the wrong one.

Your feature article (May) reporting a connection between marijuana use and susceptibility to the AIDS virus is, in my view, not at all the wild-eyed, myth-innuendo style of journalism which he dismisses as 'garbage.'

Quite the contrary. To me, it makes eminent sense.

The toxic-irritant insult of repeatedly inhaled cigarette smoke, whether tobacco or marijuana, is well known to diminish significantly the body's overall immune responses, thus predisposing it to much easier viral invasion, from whatever source.

Common sense suggests then, that such initial immuno-suppression, resulting from a smoke-muffled alarm system, clearly props the door wide open for AIDS viruses aiming at gaining a beachhead through moist mouth, genital, and anal membranes.

My prescription, therefore, for buttressing one's normal resistance to AIDS infection — and, of course, for mounting the most effective response once infected — is simple: avoid inhaling cigarette smoke.

Reaching? Far out? Wild-eyed? I think not. As supporting evidence slowly trickles in, this R_x seems even today to be well within the range of prudent medical advice.

George F. Lewis
Associate professor, anatomy
McMaster University
Hamilton, Ontario

•

Bruce McCubbin's over-reaction to your article on the United States official's linking of early marijuana use to AIDS (acquired immune deficiency syndrome) risk (May) is interesting.

The growing awareness of the link to AIDS susceptibility of previous insults to the immune system is a legitimate piece of research and is just that, awareness.

To call such a report "garbage" and to liken legitimate scientific research reports to the film, *Reefer Madness*, seems irresponsible.

Why he so defensive?

Willard S. Krabill, MD
College Health Service
Goshen College
Goshen, Indiana

Student still needs TJ

I recently have had the opportunity to become acquainted with **The Journal** through my work on a student newspaper at the University of Toronto.

I find it to be exceptionally well-written, researched, and informative, and I appreciate the effort you put into the education of the public with respect to your work.

As I am no longer certain I will be allowed access to **The Journal** in this academic year, I am asking to be put on your mailing list. Thank you in advance for your help.

Alvin Ng
Toronto, Ontario

The Journal

A week in the life of the Addiction Research Foundation

The Addiction Research Foundation (ARF) has been a part of the fabric of life in Ontario for 37 years — the first 25 of them under founder H. D. Archibald. Its mission today, as it has always been, is primarily to serve the people of Ontario.

Along the way, the foundation has acquired an enduring, worldwide reputation through its research into the myriad facets of alcohol and other drug use. Recently, for example, a number of scientists from the ARF were invited speakers at a conference in Helsinki of the International Society for Biomedical Research into Alcohol.

And in the United States, many long-serving state agency directorates acknowledge the leadership provided by the ARF long before the US National Institute on Alcohol Abuse and Alcoholism and the US National Institute on Drug Abuse came into existence.

But, length of service and breadth and depth of reputation can also be a liability. Fame attracts detractors. Frequently, the response can only be bittersweet acknowledgment, once again, of the Ontario, or the Canadian syndrome. Long-time staff and associates of the ARF have often been in the position of seeing their wheel 'discovered' beyond the borders of Ontario, with major 'new' develpments touted as breakthroughs in treatment or research that began in the ARF and have been in place in Ontario for many years — put there by the ARF.

The foundation, like every other government agency, has been subject in recent years to budgetary constraints. The ARF, with a staff of some 730, has an annual budget of almost $30 million, for a population of close to nine million; the Alberta Alcohol and Drug Abuse Commission, for example, spends $26 million a year for prevention and treatment services for a population of two million.

These are among the issues Washington Contributing Editor Harvey McConnell explored when he talked to ARF officials to examine the role of the foundation — what it is currently doing, what it hopes to do in the future.

This is the third in a series on Canadian provincial addiction agencies, prepared by staff of The Journal, and which include Alberta (August, 1985) and Nova Scotia (November, 1984).

The Diary

MONDAY
2 pm
ARF Headquarters, Toronto

Riding the tiger of balancing the various roles the foundation is expected to play provincially, nationally, and internationally is Joan Marshman, PhD, a pharmacologist by training and president of the ARF for almost five years.

President Joan Marshman talks to Harvey McConnell: first responsibility to Ontario

Dr Marshman: "Our first responsibility is obviously to the people of Ontario.

"I think, however, if one recognizes the needs of research and the research community, and how the research community does business, it is pretty obvious we do better research for having scholarly links to various people in the subfields we are studying, without reference to whether they live in Britain, the United States, Finland, or wherever.

"So, our dollars are better invested for the people of Ontario by having had these opportunities for dialogue."

In response to requests for collaborative study, the question is always: "What is the relevance of the possible outcome for the people of Ontario; we don't go into something unless we see it as a direct tie-in or directly relevant to studying the Ontario scene."

Conversely, the validity of the information which may be generated from the Ontario community in such a study may be enhanced by its being collaborative. Patterns that may be similar elsewhere would remain hidden without benefit of participation in a multi-centre study.

The truth is "basically, science doesn't stop at the boundary of any province or any country."

Dr Marshman says it would be an eye opener for many to see the range of visitors to the foundation and "the extent to which the foundation is a sought-after and highly prized source of information.

"We are always getting requests from people in Europe or from Down Under who say they are coming on a study tour primarily to the United States, but they would like to make a flying trip to Toronto to look at some specific aspect of what we are doing."

On the provincial political scene, Dr Marshman is a realist: "I believe politicians' greatest interest is in what we are doing for the people of Ontario."

In fact, only about 1.5% of the ARF budget of about $30 million is directed to international activities, a small amount considering the research programming of the foundation and the fact it is also a World Health Organization (WHO) collaborating centre for research and training in the substance abuse field.

"We believe we are making a significant contribution to the Canadian contribution to the international scene and, in fact, we believe that is not recognized in the funding arrangements."

On the national level, the ARF's influence is more informal, given that federal and provincial operations each have their own mandates and the transfer of programs across provinces or the nation is difficult.

Dr Marshman says it is a constant challenge "to try to bring the best and most relevant of our work to bear on the national scene. Sometimes, issues emerge elsewhere before they become big in Ontario, so we don't always have the luxury of mobilizing our knowledge, our statistical and information bases, and our policy. People come to us before we have started to wrestle with the issue here."

For example, Ontario is in an advantageous position on the launch of low-alcohol beverages and in keeping tabs on cocaine use, which appeared as early here as elsewhere in Canada; however, pressures around drinking and driving issues emerged more prominently in Western Canada.

Single issue advocacy, now so popular in North America, can also pose temporary commotions; the foundation wants to take a balanced view.

Dr Marshman: "The foundation's position on most issues is trying to bring the best knowledge to bear. Our positions are not taken from a moralistic or religious perspective, but from the perspective of hard data — as hard as we can get it. We try to illuminate the picture to allow the people formulating policy to weigh some of the vocal arguments and to develop policy that reflects not only the feelings people have about them, and their concerns, but also the reality as we see it in terms of a scientific snapshot or research snapshot, if you like.

"This puts a real burden on us because sometimes a movement emerges and develops so quickly we haven't got all the data at hand we would like to have. We try to bring any information we have to bear on it, and, I think, in some cases, it tempers the extremists on either side and the political reaction to them."

One issue now at centre stage is the advertising of alcohol beverages. Hovering

The Journal

A week in the life of the ARF

in the wings from its debut in the US, is voluntary or mandatory urine testing for possible drug use. Both issues are contentious, to say the least.

Dr Marshman believes that overall "where we are at in the 1980s in Canada is making people more aware of the central issue of health, and this raises important issues." The risk associated with the use of alcohol is a quality-related risk, and formulation of policy on alcohol advertising should take into account public health issues.

Clearly, children are growing up today in a different culture, in terms of mass media, than previous generations. Today, both parents and communities are saying, 'Wait a minute, you can't throw that at my kid in the way you are trying to do it.'

Technicalities of the specific advertising message are not the real issue, Dr Marshman continues. "The real issue, I believe, is the extent to which control policy recognizes the importance of public health and the lack of right on the part of advertisers to violate the public health."

This shifts the onus from the public to the advertisers, who must show from their marketing research studies on a particular message that it is *not* adverse to public health interests.

As for urine testing, the ARF is receiving more and more inquiries from industry about the issue and the possibility of analysis of samples by foundation scientists.

On one point Dr Marshman has no doubt: "I am very keen on the principle that one has responsibility for the safety of one's fellow employees and no right to jeopardize it by personal drug use behavior."

And, while the foundation is looking at the question of urine testing, although it does not have a policy yet, she is personally concerned about the use of any test results without the knowledge of the person being tested and about any interpretation of results without the person tested being given the facts.

"My background as a pharmacologist makes me very much aware of the residual drug metabolites which may be there, or intact drugs, which may be excreted for weeks and, I suppose, months in some cases, after the use of the drug."

There is also the question of passive smoking of cannabis or of an individual's receiving a narcotic analgesic at a dental visit and having it show up in a test several days later.

At the very least, says Dr Marshman, there must be informed consent, and any result must be subject to interpretation, with involvement of the person tested.

The questions concern her deeply. "You are balancing off on the one hand the benefit to the company and fellow employees in a safety sense, against the risk to the individual of being stopped in some way in regard to possible employment."

Dr Marshman sees the ARF more and more involved in discussions not only with government, on every level, but also with voluntary groups, the generic health care system, community hospitals, and various professional groups, all of whom have different perspectives.

One example of collaborative work is a beverage-server training package being developed with support from the Liquor Licence Board of Ontario and the Ministry of Consumer and Commercial Relations: different perspectives but complementary.

Dr Marshman is confident that "when you start combining the research, the community programming, and the educational resource bases within the ARF, and what they bring together, with the knowledge and perspectives of these other groups, you have very powerful access and the results are excellent."

3:30 pm
Community Services

The 30 offices of the ARF scattered across Ontario are under John La Rocque, director of the community services division. It's a vast geographic area with a multiplicity of people, programs, and problems.

Mr La Rocque and his 178 staff members have three main community responsibilities: treatment service development, the conduct of health promotion programs, and involvement with employee assistance programs in the workplace. It all adds up to working with approximately 500 organizations, assisting them in managing people with alcohol and other drug problems.

Guidelines — really statements of intent — are taken by the regional offices and adapted to local situations.

Mr La Rocque: "What we advocate is a sort of generic assessment and referral capability for people with alcohol and drug problems, that would include a systematic assessment of the individual's needs. Then, we would try to make a decision on that basis as to where the individual should be sent, not just on the basis of criteria that might exist in a particular treatment program — because there will obviously be a bias there."

Most of the division's health promotion work is centred in the school system and on assisting 82 school boards with curriculum development.

Treatment services, however, require the most time and energy of the community service staff: an ongoing project is an action plan that involves development of balanced treatment services in 35 geographic districts mapped out according to district health council and municipal boundaries.

The objective is, Mr La Rocque says, to develop a range of treatment services in each jurisdiction, starting with assessment referral capability and case management capability.

"We stress outpatient treatment because the evidence is compelling that outpatient treatment for many alcoholics is every bit as effective as some more expensive, hospital-based treatment."

4:30 pm
Personnel

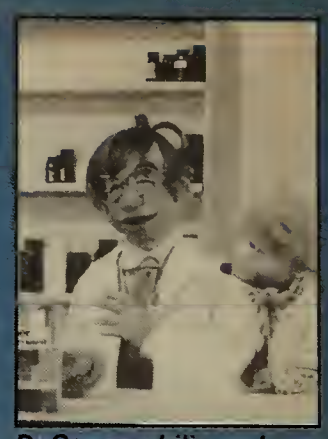
The growth of the employee assistance program (EAP) movement has, by definition, pushed personnel departments beyond the hiring and firing role to helping employees with alcohol and other drug problems.

The foundation has its own EAP program, although as personnel director Laurent Weiss explains: "We are about to rewrite it to make it more comprehensive and to take the broad brush approach."

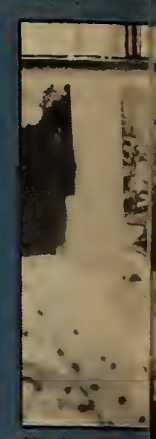
There is no bias against hiring recovering alcoholics: "If they can do the job, they are hired. In fact, we have hired a number of these people and if we can't hire them on a full-time basis because there is no job, we at least can give them a chance to hone their skills again."

Mr Weiss has kept a keen eye on the developing issue, in the United States, of pre-employment urine screening for drugs. He considers that although blanket screening would probably be an invasion of privacy,

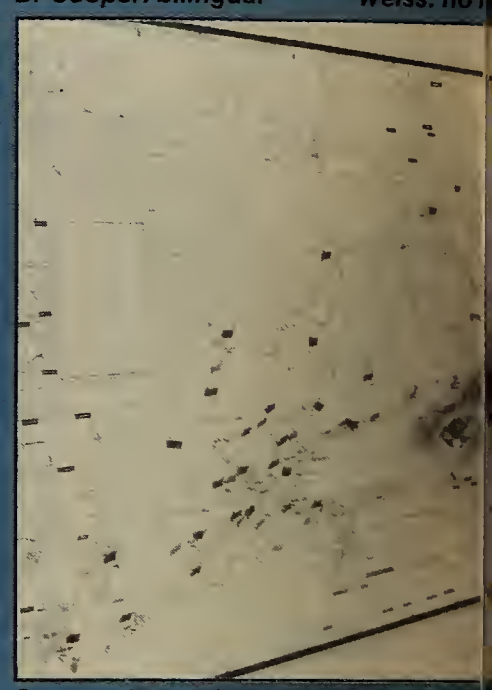
Durham bear: addiction awareness



Dr Cooper: bilingual



Weiss: no i



Community service: Ross Ar...

Prevention message: (l to r) Jackson, Antoinette Sealy, Finlay, and Simmons

Ch...

"it is reasonable even now to give a medical to someone who has to drive a van for us," or to those who have legitimate access to drugs.

TUESDAY
9:30 am
West/Central Metro

Ann Cox is director of the Toronto — West/Central Metro Centre, one of six community services offices within the Metro Toronto region.

The Metro Toronto region is a bit of a misnomer, she points out. "The region goes all the way to Burlington and Oakville in the west, east to Durham, and north to the Georgian Bay area. You might say Central Ontario would be a better name. We serve a lot of people."

The West/Central Metro Centre, for example, services Etobicoke, Toronto, and York, an area with more than one million residents.

As the head offices of most health care and social service agencies for those with substance abuse problems are in Toronto "Metro Toronto is comparatively resource rich, which is one of the things we have going for us. Our job is not so much to establish services as to enhance what we have got and do some fine-tuning and developmental work.

"I would say our people are a combination of planners and programmers; they spend a good deal of time in planning in a lot of different ways as we work with coordinating bodies, health care planning bodies, and so on to accomplish our goals."

There are difficulties as well, as Ms Cox outlines. "One is doing the job we see needs to be done, with the resources we have, while trying to orchestrate them in effective ways. A second is that that size and complexity of a metropolitan urban area like this presents difficulties in terms of organizing work, as compared to smaller cities and towns.

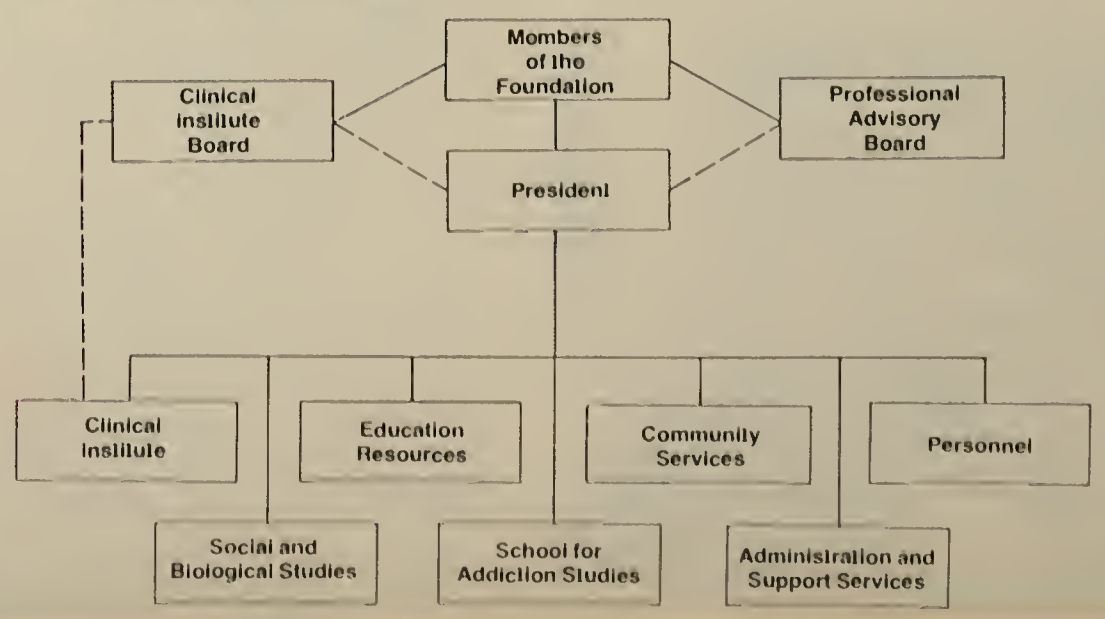
"We work through and with other organizations to a far greater extent to accomplish our aims; that makes it appear to slow up the pace of achievement, and that can be a problem."

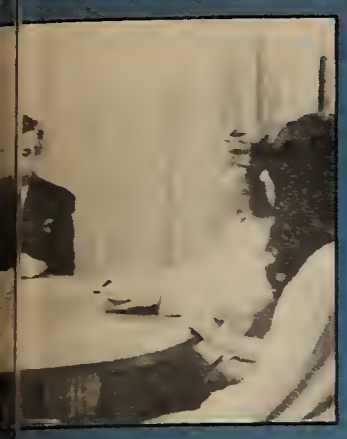
Some of the community agencies and others who want and need the services provided by the foundation are occasionally critical of the ARF's research components. Often single focused, they want "action people," and comment, 'If you are not doing treatment, what's the point?'

Ms Cox says that in recent years, "we have retooled our skills and our services to do more than just consult, and we have become involved in service development."

This, in turn, has created the expectation "that we continue to provide high powered planning and program development

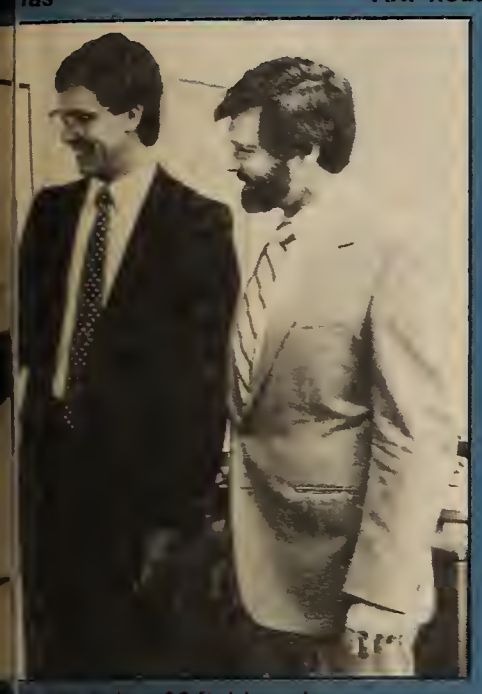
Organization structure





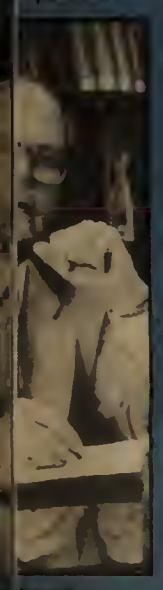
ias

ARF headquarters: research, treatment, education



cquire new 30 field centres

Bullets: Schankula (r), with Ken White



Cox: orchestrating

A week in the life of the Addiction Research Foundation

and we are seen as one of the few agencies (at the service level) with those very necessary skills."

Ms Cox: "We have come a long way in proving that research is for naught unless you can translate it into effective programs. And we have discovered there are 'many ways to skin a cat' and to implant and keep those services there."

One current West/Central Metro project includes finding out if it is possible to reduce alcohol consumption in a given sector of a small test community living within a large metropolitan area; a second is the long-term development of programs for the elderly.

One of his current projects "is going into general health and social service agencies, not addiction agencies, and saying, in effect, to them: 'You could save yourself a lot of grief if you started to screen for substance abuse among your caseloads. If you start asking about the use of alcohol and other drugs, you would begin to identify more people with alcohol and other drug problems and get them into proper treatment.' "

Mr Finlay has found this approach successful with a number of agencies, which then adopt screening procedures. Part of the package is staff development and training programs he carries out.

Ms Jackson's focus on the health promotion field includes a large number of meetings. The one she is in the middle of is to promote Addiction Awareness Week in November. The steering committee is considering everything from fund-raising through special events, to the kind of gimmicks that may bring in additional cash.

She says some 60 people across the region are actively working on different aspects of the special week. Their aim is to get as large a cross-section of people as possible involved.

Ms Simmons, who handles the street people outside the building, finds the problem with cocaine small at the moment. The quality of the cocaine in the area is poor: "It is my suspicion that a lot of people are paying $35 to snort a combination of cold remedies, procaine (eg, Novocain), and whatever else. There is about zero cocaine." The same probably goes for crack, she says.

Most of the dealers hanging around are trying to peddle what they call hashish oil; buyers don't realize whatever they get is heavily cut with either diesel oil or Vaseline.

'Bottle toking' is popular: punching a hole in the side of a pop bottle, putting the

WEDNESDAY
11 am
Durham

If the staff of the ARF Durham region office in Oshawa ever want to find out current street prices of drugs or this week's drug fad, they have only to walk out the front door of their building and look left or right. Street people hang out here, near the unemployment office and just across from the bus station.

And, the problems are here: alcohol, second-time-around amphetamine abuse, cocaine allegedly brought in from Montreal by "exotic" dancers in the topless bars. Only a few reports of crack have been heard.

The day-to-day work at the Durham office — the region has a population of 220,000 — is divided among Robert Finlay, director, and Suzin Jackson and Marg Simmons.

A large amount of Mr Finlay's time is spent in the training and education of professionals, making them aware of the problems that often lurk under the surface of people they see.

joint in, lighting up, and sucking the smoke out of the top.

A major drug of abuse which has resurfaced in the area is amphetamine. This time around the abusers are in their mid- to late-30s, people who used speed in their early 20s, came off, got married, raised a family, and now, for whatever reason, start using again.

What Ms Simmons finds paradoxical "is that these people know how easy it is to get into the speed scene and how hard it is to get off. And now that they are married and have kids, there is much more disruption of their life than when they were younger and single. Along with their speed use comes domestic violence."

This time though, she finds that when they do get into trouble with their habit, they realize they need direction to straighten out.

3 pm
Education Resources

"I think of this division as the production line of the organization: we make the bullets and other people fire them, although we have a few rifles within our division as well."

This is how Henry Schankula sees the education resources division, which he heads.

The division produces all print and audio-visual materials issued by the foundation. These range from **The Journal**, through the Dr Cooper video series for school children, to the telephone Dial-A-Fact service.

Mr Schankula: "We want to be the voice of reason for what the foundation does. We want to position ourselves in the marketplace as the purveyor of absolute truth as it exists today: if you want the best scientific information about a particular drug, we are here to provide the honest information, good and bad, what we know and what we don't know.

"That position of scientific integrity and credibility of anything the foundation does has to be maintained."

Walking the scientific tightrope means getting shot at at times, charged with being either too soft or too hard on particular drug issues.

It's the price of taking a central position.

The Dr Cooper series features a puppet-scientist who conducts various experiments, generally in a laboratory situation, examining the effects of various drug products. The age target range is large.

"It is a fast-paced sort of program dealing with topical issues, from medicine cabinet drugs through garden products, aimed at the younger viewers, right through to the upper level of the school system, dealing with alcohol, solvents, and other issues," Mr Schankula points out.

The series proved so popular the federal government has given a $100,000 grant to produce the series in French.

More than 80% of the material produced by the division is bilingual.

Dial-A-Fact — taped messages on a range of drug-related subjects — has grown in the past three years, partly because of budgetary constraints. Mr Schankula: "We were getting about 20,000 calls a year to operators. We took the most frequently asked questions and began to experiment with a tape response series.

"We still get about 20,000 calls a year to operators, but we also get 60,000 to 70,000 calls to Dial-A-Fact, so this is an entirely new market."

The bank of 65 tapes in English and French is manned by a bilingual operator. Some 10 tapes — those dealing with issues related to alcohol, cannabis, cocaine, caffeine use, and sexual issues and drugs — receive about 50% of the calls.

Other provinces in Canada are using the tapes, and the Netherlands and Finland have emulated the system. Mr Schankula believes it could be expanded for a proposed health information system in Ontario.

The foundation does not advertise on television, although it does produce public service vignettes. One reason is that there are no funds available, and even if there were, there would be question marks. "A few years ago we had a task force study, and one of the outcomes was that there isn't sufficient evidence that counter-measure advertising is worth the expenditure." Mr Schankula says.

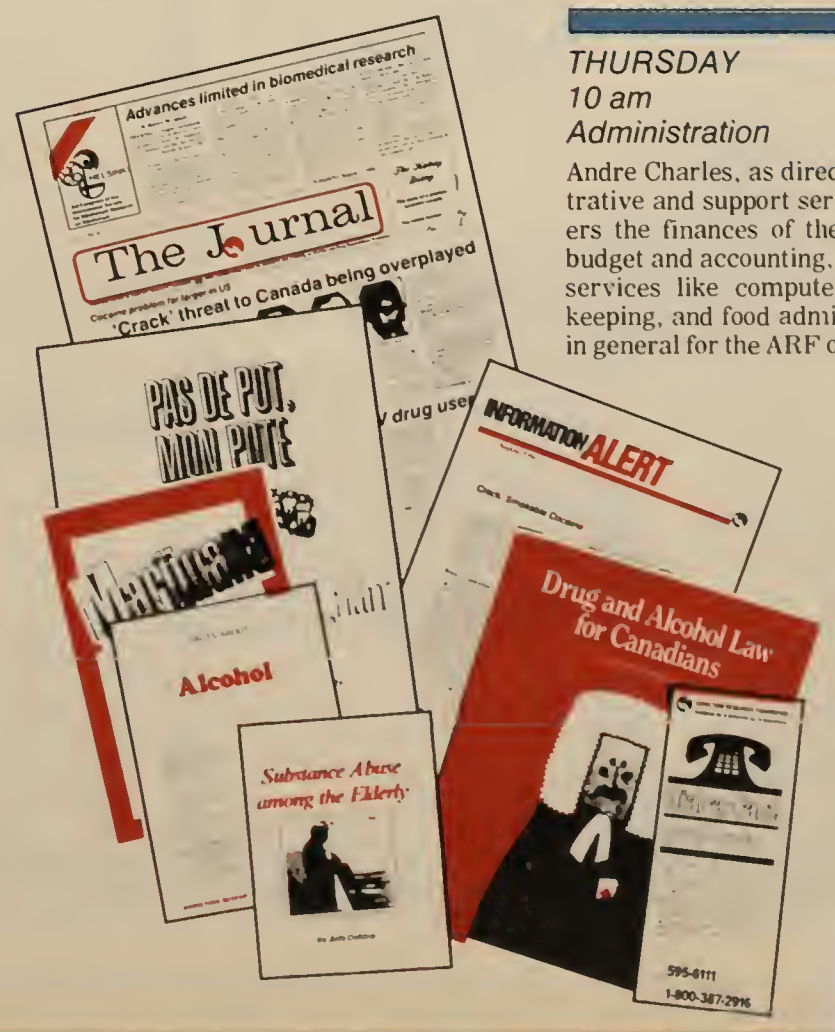
In some ways, he would like to advertise Dial-A-Fact and some other products, but "if we advertised all the products we have available, we wouldn't have the supply to meet the demand."

A future ideal is to develop what Mr Schankula describes as "teacher proof" materials for schools. It would be materials which the teachers would be conversant with and could immediately use for a 'teaching moment.'

Mr Schankula: "For example, you would not only have alcohol and other drug information taught separately; if the issues came up in, say, social studies, civics, economics, or geography, all the teachers in all the subjects would also have access to and be familiar with what is available."

THURSDAY
10 am
Administration

Andre Charles, as director of the administrative and support services division, covers the finances of the organization, the budget and accounting, as well as in-house services like computer services, housekeeping, and food administration services in general for the ARF offices in Ontario.



Education: providing the best scientific information

The Journal

A week in the life of the ARF

Mr Charles also oversees all of the foundation's rented properties, as well as four or five properties owned outright. Not owned is ARF headquarters at 33 Russell Street, which is rented by Ontario's Ministry of Government Services for a fee of $1 a year. The foundation has complete responsibility for the building.

2 pm
Social and Biological Studies

Two contrasting fields — biological studies and prevention studies — are the responsibility of Howard Cappell, PhD, director of the social and biological studies division. He was familiar with the first as a researcher, but now finds the applied science of prevention, after 18 months in the position, appeals as much.

He explains that the behavioral research department is concerned with the biological mechanisms involved in drug addiction, how these contribute to acquiring a drug-taking habit and maintaining the habit, and how they can be manipulated to reverse the situation.

Studies also include the mechanisms involved in tolerance to drugs, physical dependence, and the organic damage caused by excessive exposure to drugs.

The central theme of the studies is the role of the brain in all of these phenomena.

The prevention studies department, on the other hand, searches for techniques which can be applied fairly immediately to prevention of problems known today to be caused by alcohol and other drugs.

Dr Cappell, who recently completed a study of dependence in people who were taking no more than therapeutic doses of benzodiazepines for a long time and found this to be a *bona fide* addiction, is excited and enthusiastic about prevention programs.

"I used to have a fairly jaundiced view, like many people closer to mechanisms and pure things. But, once I got to see how valuable and important applied science is, and that people out there really need it and want it, the field excited me. My major ambition is to push and support that activity, to get the knowledge outside these walls.

"And even though our ability to know and control isn't as perfect in one area as it is in the other (biological), it's better than nothing, a lot better than nothing. So, I have become a convert to the value of doing these things."

Some prevention activities include a study of a way to offer services in a small community in a bid to affect alcohol consumption.

Another is to implement workplace programs to help those with alcohol and other drug problems, with the presumption that if it helps people in the workplace, it will help them at home as well.

The knowledge the foundation has in relation to road safety is being linked with the Liquor Licence Board of Ontario and the board's interest now in having a health perspective on regulatory activity.

The proliferation of knowledge in recent years about the brain and its receptor sites has produced an enormous research thrust. At the foundation, there is a concentration on opiate receptors, how patterns control drug-taking behavior, and how they might possibly be manipulated.

There is also an attempt to develop an animal model for alcohol to identify the brain mechanisms. It is not easy, as Dr Cappell explains: "Developing an animal model for heroin addiction is not too hard, but developing an animal model for alcohol addiction is awfully difficult."

As for the future: "It is the case, and will continue to be the case, that most of the social and economic costs that we suffer are from alcohol."

There is always a pressure for results in combatting these high costs, and the aim based on economic reality is to try to see if, in contrast with the US, the same or better results can be achieved for less money.

FRIDAY
10 am
School for Addiction Studies

The School for Addiction Studies is the newest (1978) division of the foundation and was established to bring together the best talent, planning, and teaching resources of the ARF and slot them into a training and development system.

The original focus was ARF staff, but in the past three years priority has been given to people from communities in Ontario.

This idea has been extended into programs all across the province in conjunction with community service programs: community events, seminars, workshops, a radio course on station CJRT, and teleconference programs beamed mainly at Northern Ontario.

And, while the well-known summer school courses are mainly for community personnel from Ontario, there is now a large contingent of participants from the US, the Caribbean region, and other countries as far afield as Nigeria, Thailand, and Britain.

Director Donald Meeks, DSW, explains: "Last year, we offered 60 courses and had 2,000 participants. We charge more to people outside Ontario as part of our cost recovery program.

"We have a stable interest in treatment techniques, research, and community development, but we are also able to keep abreast of new knowledge by involving people from the foundation, many of whom are on the leading edge of these subjects."

Dr Meeks is also ARF's coordinator of international training programs. This involves activity in Toronto and abroad.

"We bring in a fair number of people for study and training visits, which can range from a couple of weeks to a year and can occur in any discipline of the foundation. In addition, we provide technical consultation on behalf of the WHO, the United Nations Fund for Drug Abuse Control, and the International Council on Alcohol and Addictions."

Dr Meeks is co-director of a Caribbean training institute, which has run for the past 12 years in the Virgin Islands and involves 60 to 70 professionals in an intensive training program. Funding comes from a wide variety of sources — the Canadian International Development Agency (CIDA), the Smithers Foundation, Pan American Health Organization, and Amoco of Trinidad. The ARF provides no financial assistance but gives technical support.

A similar training program, though not so large, has been carried out in Africa.

Dr Meeks: "One of the striking things about our involvement in the training area is that for a little cash investment on ARF's part, we have been able to have a tremendous impact on development in the area. Now I think we are as well-known in many regions for what we have done in training as for what we have done in research."

But, changes don't happen overnight. As Dr Meeks has learned, "after 20 years in the field, you have to deal in the art of the possible, and you have to think about gains in increments.

"You cannot go into a country and expect to win the game, abolish, or eliminate. But if you can deal more effectively with casualties and introduce prevention programs, then you can feel a sense of accomplishment."

Dr Meeks keeps the same perspective about the school: "Although we are involved in international programs, our major focus is still on the province of Ontario and on our involvement with such things as programs for Native Canadians, inter-cultural differences, sex differences, women and alcohol, the elderly and alcohol, youth and alcohol, and so forth."

2 pm
Clinical Institute

No one questions the need for treatment for those with severe alcohol and other drug problems: the quandary is what treatment regimens are the most efficient.

This is one of the questions being asked at the foundation's Clinical Institute, and some people don't want to hear what the latest research indicates, says Ed Watson, institute director.

It has evolved from the institute's three main missions: to study treatment of individuals who have alcohol- and other drug-related problems, to do targeted clinical research that can help improve the quality of care for both the patient and those who provide it, and to train manpower in the addictions-related fields.

These insights are passed on to the government and other interested organizations in the field.

Mr Watson: "One of the things that sort of swirls around the institute and its approach to treatment, and on which we have developed significant research, runs counter to conventional wisdom.

"This conventional wisdom is that if you have a serious alcohol or other drug problem, you have really got to get yourself hospitalized. And, you are going to have a team of medical folks swarming over you for three weeks, or a month, or more, in order to get a cure or get the problem under control.

"Some of our research indicates that brief outpatient or an educational kind of focused treatment may be every bit as effective as high-cost institutional treatment.

"That is not what a lot of people want to hear, and it runs counter to many people's perception of what constitutes good treatment, or what is an appropriate response to the problem."

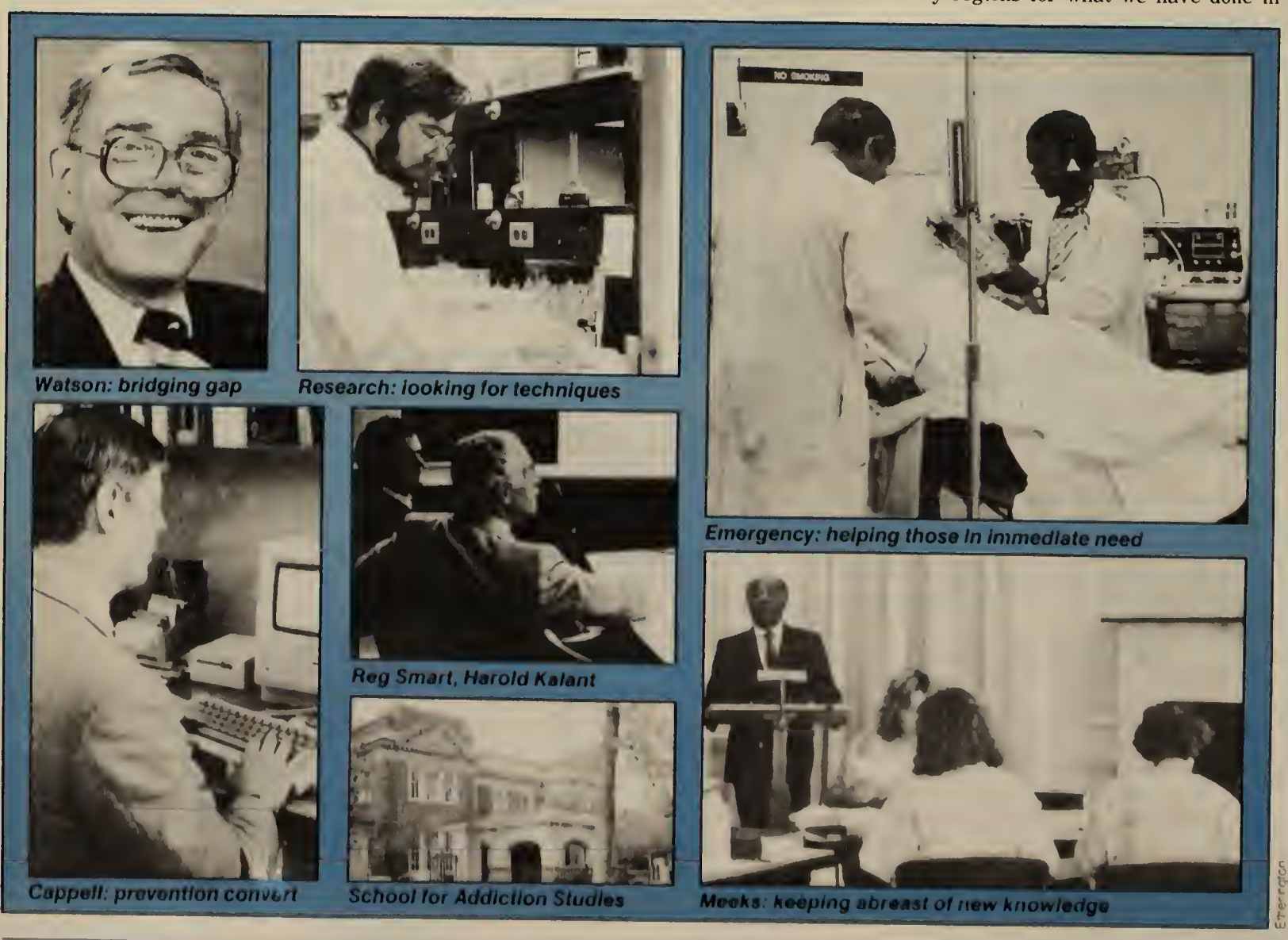
Mr Watson sees the institute as a rather unusual place in that it brings research and education of manpower for the field into one institution. Different perspectives have to be balanced.

Many researchers would be quite happy to be left alone to do their work until they publish their papers in scholarly journals. Some treatment people see research as somehow casting people in the role of subjects rather than human beings with 'here and now' problems that need considerate and informed professional help.

Mr Watson sees education as bridging the gap. There has been a rotating medical residency program in the institute for many years, plus training of social workers, nurses, and those involved in psychology, occupational and physical therapy, pharmacy, psychiatry, and family and community medicine.

He finds he is involved in a balancing act and is constantly asking himself, 'Are we putting our eggs in the right basket, or are we putting enough eggs in certain baskets, and do we need to put any eggs in others.'

Mr Watson: "The research we are doing is quality research, it is scrupulous, it is competent, it meets all the quality criteria. But, it does not mean necessarily that at the end of two years we are going to have some profound breakthroughs that are going to make an enormous difference in the way in which the problems of alcohol and drugs are dealt with."



Watson: bridging gap

Research: looking for techniques

Emergency: helping those in immediate need

Cappell: prevention convert

Reg Smart, Harold Kalant

School for Addiction Studies

Meeks: keeping abreast of new knowledge

Etherington

British bill ready for parliamentary approval

Council of Europe leads on drug forfeiture law

By Thomas Land

OSLO — Several West European countries are expected to legislate shortly to provide for seizure of drug traffickers' financial assets.

The move is led by Britain and coordinated by the 21-nation Council of Europe. Such a common policy has been long advocated by Canada (**The Journal**, November, 1985), the United States, and several other nations frustrated by the ability of international criminals to escape justice by taking advantage of the complexity of Europe's varied legal systems.

Both houses of parliament in Britain are set to pass a bill later this year containing provisions for international treaties enabling countries to recognize each other's court orders on serious drug offences.

And, a communiqué issued after a conference here of justice ministers, brought together by the Council of Europe, now promises urgent, coordinated action by members "to ensure the effective punishment of drug traffickers and the confiscation of their assets." (Canada and the Holy See were meeting observers.)

Britain's drug trafficking bill, which will likely set the pattern for Europe's legal reform, will allow reversal of the burden of proof after conviction, empowering the courts to order the offender to bring assets back into the country or face an additional, mandatory sentence of up to 10 years' imprisonment.

The legislative program coordinated by the Council of Europe is to ensure court orders issued in one country of the region are enforced in another.

Western Europe has been spurred into joint legislative action by fears of a dramatic escalation of the drug trade: about 1,500 kilograms of cocaine and 730 kg of heroin were seized by regional law enforcement authorities in 1985.

The Council communiqué describes the medical and social implications of the escalation as culminating in "one of the most serious and complex problems" facing member countries.

The latest situation report issued by the United Nations International Narcotics Control Board (INCB) says illicit drug trade is prevalent throughout Western Europe, with heroin and cocaine doing the greatest damage (in descending order) in Britain, France, Holland, West Germany, and Italy.

For the conference here, the size of the problem was defined by a confidential working paper from Denmark. Its authors say up to 30 tonnes of cocaine have been smuggled into Europe during the past two or three years. And, the current stagnation of cocaine abuse in North America is likely to result in more.

Council logo

Alarmed by the trend, justice ministers have asked the Council to consider the wider political implications of a coordinated regional policy embracing "active" methods of investigation, including greater use of undercover agents, anonymous witnesses, and telephone tapping.

They emphasize: "The penal aspects of drug abuse should not be considered in isolation, but as part of a policy of medical and social development, with proper regard to prevention and treatment."

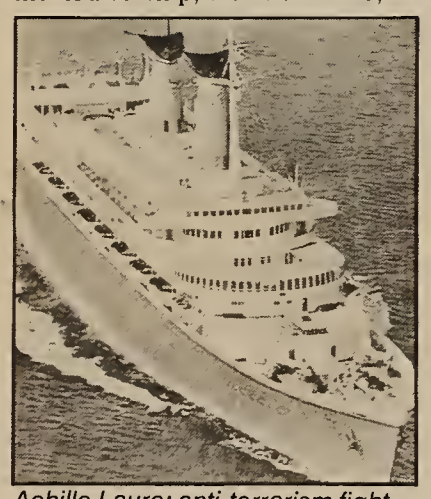
The communiqué also advocates "the formulation of international norms and standards to guarantee effective regional cooperation between judicial (and, where necessary, law enforcement) authorities as regards to the detection, freezing, and forfeiture of the proceeds of illegal drug trafficking."

Seaworthy program to fight drug smuggling

By Thomas Land

LONDON — Member nations in the United Nations International Maritime Organization (IMO) are studying a set of practical proposals for the prevention of drug smuggling in commercial ships. A draft measure is expected shortly.

The measure has evolved from discussions originally intended to fight international terrorism. The talks began after the hijacking of the cruise ship, *Achille Lauro*, in October, 1985, which led to the death of a 59-year-old United States passenger.


Achille Lauro: anti-terrorism fight

The proposals developed by the IMO are based on recommendations made by the United States and information provided by the UN International Air Transport Association (IATA) in Montreal. They are similar in many ways to those already adopted by IATA for airport security.

"These measures are intended to enhance security at passenger terminals and on board ships in international voyages," says a specialist spokesman for the London-based IMO.

"They can be employed by governments, port authorities and administrators, ship-owners, operators, masters, and crews."

The IMO's guidelines are being developed with help from the Customs Cooperation Council and the International Chamber of Shipping to cover these areas:

- preventing drug smuggling on board ships and ensuring detection if they do get there,
- discouraging seafarers from drug trafficking and drug abuse,
- education and training,
- information about the types, nature, and characteristics of commonly smuggled drugs.

In addition, the anti-terror measures would impose minimum safety rules for cruise vessels, including passenger security checks at embarkation. The IMO also proposes warning travellers against using unsafe cruise lines.

The proposals are now under consideration by IMO members and are expected to be finalized at a London conference soon.

UN organizations were asked by the General Assembly last December to seek ways of improving transport security in the face of increasing internationally organized crime, including drug smuggling and terrorism.

The IATA has concluded its security review. Its new measures include fresh controls on the movement of catering and cleaning staff with access to aircraft and stringent security checks on unaccompanied baggage.

New, high-technology equipment to identify drugs, guns, and explosives are to be installed at selected airports immediately (**The Journal**, August).

New Zealand hits tobacco trade with 'body blow' increase in taxes

AUCKLAND, NZ — New Zealand smokers are reeling under the impact of the largest increase in tax on cigarettes since tobacco was first taxed 107 years ago.

A 162% rise in sales tax announced in the latest budget has lifted the price of a packet of 20 cigarettes to $2.68 from $1.75 (Cdn to $1.86 from $1.22).

By raising the tax to 105% from 40% of wholesale value, the government is increasing its share of the retail price to 71%.

The increase has stunned the tobacco industry which sees it as a "body blow."

It exceeded even the dreams of the anti-smoking lobby, which asked for a price rise to $2.50.

HOWELL

Alice in municipal wonderland

Curiouser and curiouser, thought Alice. A Mock Turtle, a Walrus and a Carpenter, and a hookah-smoking Caterpillar. What strange and mysterious creatures she had met since she had impulsively followed the White Rabbit down the rabbit hole. And now, what was this? A Hatter, a Hare, and a Dormouse at tea!

"Come in, come in," cried the March Hare when he spied Alice.

"You're just in time — take this down," commanded the Hatter. He thrust a pen and pad into Alice's hands and began to pontificate in grandiloquent fashion.

"We, the Executive Committee of the Wonderland Municipal Government Association, once again express our heartfelt displeasure at your arbitrary and capricious abrogation of Public Morals By-law number . . . ."

"Wait a minute," interrupted the Dormouse, peering at Alice with sleepy but quizzical eyes. "She's not writing shorthand, she's not even a secretary."

"I don't know what's going on," confessed Alice, putting down the pad on which she had been frantically scribbling.

"I'll tell you what's going on," shouted the Hatter, "we're the Wonderland Municipal Government Association, and we are sick and tired of the Queen and her courts striking down every well-meaning by-law we come up with.

"I mean, who else is better able to legislate morality on the community level than municipal politicians? That's grassroots democracy, is it not? Well isn't it?"

"I don't understand," said Alice.

"It's simple," said the March Hare. "We like to think we are responsive to the wishes of our municipal constituents, the consensus of the wishes of our constituents that is.

"So when our constituents wanted to ban certain books from the school library, we passed a by-law that would do just that. When they wanted to ban racy magazines from smoke shop shelves, we passed a by-law that would do just that.

"And when they wanted to get rid of ladies of the night soliciting during the day, we passed a by-law that would do just that.

"But on each and every occasion when we attempted to take control of our own destiny, exercising our own democratic rights, the Queen and her courts shot us down; on each and every occasion, the Queen and the courts said that legislation in those areas was not our prerogative. It's not fair, I tell you."

The Hatter, the March Hare, and the Dormouse began to weep copious tears at the unfairness of it all. And in the midst of this, who should appear but the mysterious White Rabbit. He unrolled a parchment and began to read a message from the Queen:

"Her Majesty recognizes the efforts of the Wonderland Municipal Governments to control, by means of by-laws, morality in their respective communities. Her Majesty realizes that recent court decisions have thwarted these efforts. Her Majesty wishes to make amends. Let it be known to all and sundry that from this day forth, the option of having beer and wine in corner stores will be entirely local. Let the municipal governments decide: let grassroots democracy prevail."

Alice broke into spontaneous applause. Her companions, much to her amazement, broke into spontaneous sobs. The Dormouse, in particular, seemed especially disconsolate.

"But isn't this exactly what you want?" asked a puzzled Alice. "Isn't the Queen allowing the local community to decide what is best for it?"

"I'd sooner hold a referendum on funding for Catholic schools than an referendum on booze," moaned the Dormouse.

"I'd sooner take a stand on abortion than a stand on this," sobbed the March Hare.

"Take this down," commanded the Hatter. Poor Alice began scribbling again:

"We, the Executive Committee of the Wonderland Municipal Government Association, do earnestly beseech that the bitter cup of local option bypass our lips. Notwithstanding our proud forays into prostitution and pornography law, when it comes to booze legislation, we are disposed to have it opposed. And, furthermore . . . ."

Alice never did discover what the furthermore was, because the White Rabbit ushered in what appeared to be a wedding procession. And, it turned out, it was a wedding procession.

The Hatter put on his chain of office and married the two supplicants on the spot. They were a singing duo, and they had married each other so that they could get a 'special occasion' permit to have drinks served to the various newspaper critics and recording industry executives they had invited to their debut public concert.

No marriage, no drinks, so they got married.

That's how things were done in Wonderland, the March Hare explained. Of course, when Alice, who had never heard of Ontario, heard this, she knew she must be dreaming: things like that didn't happen in real life.

By Wayne Howell

INTERNATIONAL

Early problem identification saves money

London hospital shows alcohol screening works

By Alan Massam

LONDON — An attempt should be made to identify positively people with drinking problems among patients entering hospital.

The screening would give doctors an opportunity to prevent irreversible, physical and psychosocial, drink-related problems and thus lead to a substantial saving to the exchequer.

That is the simple conclusion of Sam P. Lockhart, MD, and colleagues at St Charles Hospital, West London, reported in the *Journal of the Royal Society of Medicine*.

They say 27% of 104 general medical unit admissions were attributed to alcohol consumption, although only 10 of these 28 patients had classic alcohol-related symptoms.

It was found that questioning patients on the amount of alcohol consumed was the most accurate method of screening. The brief Michigan Alcoholism Screening Test (MAST) was used.

Only 13% of admissions were defined as problem drinkers, suggesting the harmful effects of alcohol were not confined to alcoholics, the doctors report.

Commenting on the findings in a lead article, Paul Wallace of St Mary's Hospital Medical School, London, says it is difficult to calculate the cost of drinking in terms of its harmful effects.

"Estimates run at around £1,000,000,000 (Cdn $2.12 billion), but it is impossible to state with confidence.

"Screening for patients at risk because of their drinking has been shown to identify large numbers of previously undetected cases in the community and proportionately more in hospital populations."

Dr Wallace says the St Charles Hospital study and other research suggest a rationale for the systematic screening of patients at risk because of drinking. This would allow, he stresses, advice to be given before irreversible physical or psycho-social symptoms develop.

Dr Wallace says the Lockhart paper adds to growing evidence that alcohol is an important contributory factor in a large proportion of acute admissions to hospital.

Yet, nearly two thirds of these patients do not present with any of the classic features of alcohol-related illness and, therefore, would likely remain undetected as being at risk.

Dr Wallace: "There is now little doubt that, for the purpose of screening, questioning about alcohol consumption is superior to the use of laboratory tests. Clinical suspicion should remain paramount, with laboratory tests regarded as a back-up."

Ataxia is better alcoholism sign than prior care or complex tests

AUCKLAND — Clinical assessment of failed muscle is a more consistent guide to chronic alcoholism than a previous history of intervention by a therapeutic agency, or more complex tests, says a researcher here.

A standard physical and laboratory examination was given to 561 male patients admitted consecutively to a detoxification program operated by the Salvation Army here.

Data were used to develop an artificial index of alcohol-related toxicity quotient (ARTq), the percentage of normal results among a defined array of 26 tests, to describe patients within a single parameter.

This allowed patients to be compared for severity of alcohol injury and clinical tests to be compared as markers of chronic alcoholism, reported the program's medical officer, M.E. Wood, in the *New Zealand Medical Journal*.

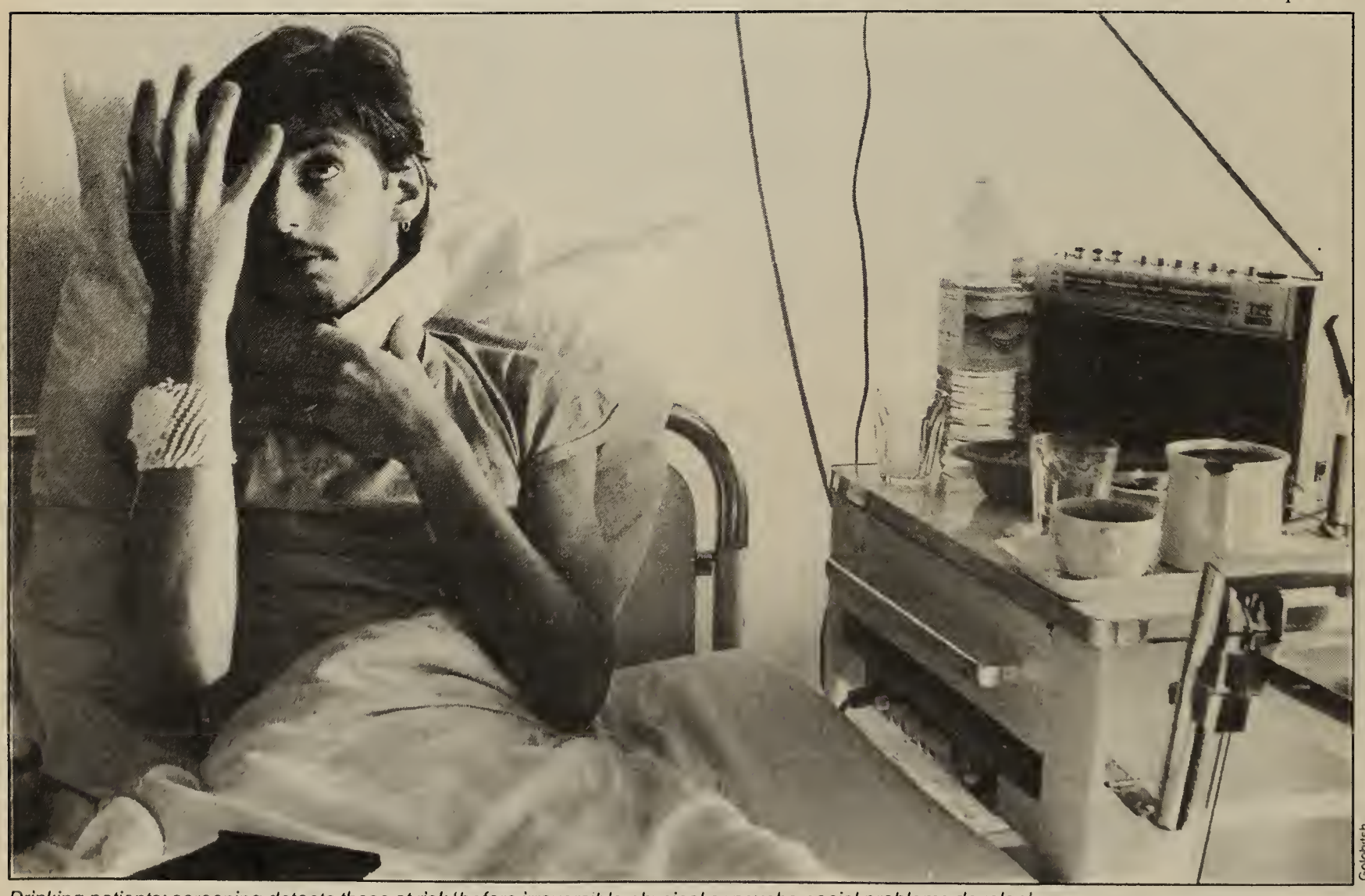
After an average of 12 days sobriety, patients were clinically assessed for ataxia which proved a more consistent guide to chronic alcoholism than previous therapeutic intervention, or tests of mean cell volume (MCV) or gamma glutamyl transpeptidase (GGT).

"However, the ARTq correlates with each of these indices better than they correlate between themselves," Dr Wood says.

Of standard tests, blindfold ataxia (failure to stand on one leg for more than five seconds with eyes closed) ranked highest overall, with MCV and GGT second and third respectively.

Dr Wood says the data indicate ARTq is quantitatively related to the severity and duration of alcoholic injury and is, therefore, a scalar index of the severity of alcoholism.

"In practice, ARTq also proved valuable in communication with social and legal workers and with the patients themselves," he adds. "It was particularly useful in following progress from admission to admission and in demonstrating continued improvement, despite setbacks, and continued deterioration, despite denial."



Goldbitsh

Drinking patients: screening detects those at risk 'before irreversible physical or psycho-social problems develop'

Doctors are vital in addictions prevention: WHO report

GENEVA — Doctors and other health professionals are to be the focal point of a forceful information program intended to reduce drug abuse.

The program, mounted by the United Nations World Health Organization (WHO), follows the publication of UN statistics putting the number of registered abusers at more than 14 million worldwide.

The statistics are compiled on the basis of official returns made by governments to the UN, estimating the global population of registered drug abusers at 14.6 million.

But, the WHO cautions, "since they include only patients registered for treatment and contacts with police and the courts, the statistics necessarily underestimate rather than exaggerate the true situation." The majority abuse cocaine and number 4.8 million. Registered heroin users number 750,000.

The World Health Assembly, the highest decision-making body of the WHO, recently called for measures to reduce the "inappropriate demand" for narcotic and psychotropic drugs and to provide treatment for patients with drug problems. A discussion paper just published by the WHO explains: "The very considerable benefits from the appropriate use of psychotropic drugs can be offset by their abuse.

"Psychotropic drugs are sold over the counter without any prescription in a number of countries.

There is also inappropriate prescribing by physicians who use medication where alternative treatment would do. And, there is misuse of drugs because insufficient or misleading information is given to the patient."

The WHO has just completed and is about to publish a manual and guidelines for teaching alcohol and other drug dependence in medical and health institutions.

"A notable feature of this," says a WHO spokesman here, "will be the clearer definition of the role of the physician and other health workers in the prevention, early recognition, and treatment of drug problems."

This clarification is especially important, he adds, because many doctors have, in the past, considered drug abuse to be mainly the province of legislation, law enforcement, and social welfare, rather than a matter for health services.

Few people changed consumption patterns

Effect of Finnish alcohol strike over-rated

BUDAPEST — A four-week strike by the Finnish State Alcohol Company *(Alko)* retail staff caused only a small minority of drinkers to alter their consumption.

Finnish newspapers and magazines depicted the 1985 strike as a major event, having drastic effects on people's lives. But, a study conducted by Esa Österberg and colleagues at the Social Research Institute of Alcohol Studies, Helsinki, found "a world of difference between . . . what the press wrote during the strike" and their chief finding that "the strike only affected a small proportion of the public as far as drinking habits and procuring alcohol were concerned."

Sales of medium beer (available in cafes and restaurants) grew by roughly 50% during the month-long strike. The study attributes this growth "to a small number of hard drinkers (who) account for the lion's share of Finland's consumption.

"One tenth of the public knock back half of all the alcohol the country drinks. It was this minority," the report concludes, "which reacted most strongly to the strike."

Asked if they cut down their drinking during the strike, 7% of women and 9% of men replied they had. Among frequent drinkers, the corresponding figure was 20% for women and 12% for men.

Lessening the strike's impact was the fact that nowadays "most Finns have considerable stocks of alcohol at home," Ms Österberg told the 32nd International Institute on Prevention and Treatment of Alcoholism here.

Quoting a 1984 drinking habits survey, which shows one in three adult Finnish males drink only once a month at most, the researchers note the strike had little effect on most people, "since few people's lives revolve around alcohol."

The study also found that while overall quantities involved were low, the strike seemingly brought about an increase in brewing and distilling at home.

NEWS

Coke users are looking more like other drug addicts

WASHINGTON — Cocaine's increasing affordability and availability has changed the psychological profile of those at risk of becoming abusers, says a team of Massachusetts doctors.

They told the annual meeting here of the American Psychiatric Association that cocaine abusers are now more closely matched in terms of psychopathology to other drug-dependent patients.

Traditionally, a high percentage of cocaine abusers were diagnosed as suffering from affective disorders such as major depression, narcissistic and histrionic behavior, hyperactivity, inflated self-esteem, and irritability.

However, as cocaine use has become more widespread, "the prevalence of affective disorders among cocaine abusers decreased significantly to 29.7% in 1982/84, from 53.3% during 1980/82."

The study, by researchers from the Alcohol and Drug Abuse Research Center, McLean Hospital, Belmont, Massachusetts, and the Department of Psychiatry, Harvard Medical School, Boston, examined a sample of 94 hospitalized cocaine abusers and compared them with 219 hospitalized patients dependent on opiates or central nervous system depressants.

Psychological testing showed the cocaine abusers had higher rates of affective disorders than the other drug-abuse patients and that an affective disorder was also more common among first-degree relatives of cocaine abusers. But, the researchers said: "In looking at drug use trends over time, we found that the differences between the two groups are narrowing."

In addition, they said anti-social personality disorder, which earlier investigations found to be confined almost exclusively to opioid addicts, is becoming more common among cocaine-dependent patients.

The Massachusetts team identified three major subtypes of chronic cocaine abusers in the sample:

- patients with major depression or attention deficit disorder, who may initially use cocaine as a form of self-medication;
- patients prone to mood swings (cyclonic or bipolar disorders), who use cocaine primarily when euphoric or hyperactive to prolong these states; and,
- patients with characterological problems (such as anti-social personality disorder), for whom cocaine use serves their own particular psychological or interpersonal needs.

They suggested different treatment strategies be used for the varying subgroups of cocaine abusers.

Amsterdam addicts get AIDS alert

By Kate Fournis

AMSTERDAM — The city health department here has launched a three-pronged program to curb the spread of AIDS (acquired immune deficiency syndrome) among intravenous (IV) drug addicts.

The approach includes a publicity campaign, an exchange system for syringes and needles, and distributing condoms to addicted prostitutes.

The city has only two AIDS cases reported among addicts, Dr E. C. Bunting and colleagues from the Municipal Health Service here report in a letter to *The Lancet* (June 21).

Blood tested in late 1983 and early 1984 showed 3.4% of 145 addicts entering methadone programs were infected with human immunodeficiency virus (HIV), the agent that causes AIDS, and 23% of 52 addicted prostitutes were antibody-positive.

(HIV is the new, standard designation for the AIDS virus, recognized last summer at the international AIDS conference in Paris. It had been called HTLV III, particularly in the United States.)

The publicity campaign involves distributing leaflets and holding information meetings for addicts and addiction workers.

Because of disappointing results with its drug rehabilitation programs in the 1970s, the city changed its approach, working to reduce the risk of addicts harming themselves or others. In addition to rehabilitation and resocialization programs, Amsterdam emphasizes street work, medical assistance, and outreach methadone programs.

In 1985, 60% to 80% of the city's addicts were in touch with the city's programs.

Because HIV is transmitted through sharing contaminated needles and syringes, a strict exchange program was developed. Started in 1984 by the Municipal Health Service and the Association of Drug Addicts ("junkies' union"), the system insures that addicts receive sterile syringes and needles free of charge when they return used equipment.

In 1985, 100,000 syringes and needles were provided under the plan, and there has been no evidence of an increase in needlestick accidents among the general population.

The approach has not appeared to encourage further drug addiction or keep addicts from seeking treatment. The number of IV addicts did not increase in 1985, and treatment programs report that "more clients than ever are being motivated to enter treatment."

The number of drug addicts in Amsterdam has stabilized during the past few years at 7,000 to 8,000.

The final prong of the program involves distributing condoms among addicted prostitutes.

DEPARTMENTS

New Books

by MARGY CHAN

The Diagnosis and Treatment of Drug and Alcohol Abuse

. . . edited by Sidney Cohen and James F. Callahan

This is a practical and concise reference for physicians and health professionals in the alcohol and other drug addictions field. The chapters on diagnosis include some helpful tests for patient assessment as well as discussions of the most common medical complications of drug abuse. Other topics include: responding to common emergencies, specific approach to the treatment of substance abusing patients, pharmacotherapy, sociotherapy, and experimental treatment modalities.

There are a number of useful resource references in the appendices. Resources for training the physician and health professional in drug, alcohol, and prescribing, for example, is a consolidation of many different education sources in self-instruction and teaching. Prescribing practice resources include references to texts and organizations interested in the problem and prescribing for specific indications. References for the impaired physician, pharmacist, nurse, and dentist are also included.

The Hawthorn Press, New York, NY. 305 p. $39.95. ISBN 0-86656-479-9.

Alcohol Detoxification Services: A Review

. . . by Jim Orford and Tim Wawman

Commissioned by the Department of Health and Social Security for England and Wales, this book is a review of the literature on the evaluation of alcohol detoxification services. It covers literature from Britain, the United States, and Canada.

The literature shows there is much confusion and differences of opinion about the aims of detoxification and the question of priority users of these services. The lack of clearly identified goals, compounded with the existence of a wide variety of types of services, renders the task of evaluation even more complex. As a result, the review argues, it is difficult to draw valid and generalized conclusions about effectiveness.

The issues of rehabilitation and decriminalization as evidenced in the literature are also reviewed. The book concludes with a number of suggestions for future direction of alcohol detoxification services planning and evaluation.

DHSS Leaflets Unit, Stanmore, Middlesex, England, 1986. 174 p. £5.

Healthier Workers: Health Promotion and Employee Assistance Programs

. . . by Martin Shain, Helen Suurvali, Marie Boutilier

Although both employee assistance programs (EAPs) and health promotion programs (HPPs) increasingly are found in organizations, the two programs generally are not planned or carried out in coordination. The book argues that the two apparently divergent health interventions should be treated in a unified, comprehensive approach for the mental and physical health of people in the workplace.

The authors also attempt to examine the role of EAP and HPP practitioners and address the need for a balance between employee and employer interests. The appendix contains a course outline, "Take charge: a self-help course in feeling better and living longer," and an extensive bibliography.

Lexington Books, Toronto, Ontario 1986. 270 p. $38.95. ISBN 0-669-09908-2.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Cocaine: The Emerging Facts

Number: 746.
Subject heading: Cocaine.
Details: Two, 20-min filmstrips with audio tapes.
Synopsis: The first filmstrip is Sarah's story. Sarah seems to have everything: she is attractive, a good student, and has a good relationship with her friend Brad. One day, however, she goes to a party where she tries cocaine. She loves it and starts using it regularly. Her marks go down, her parents are upset, she no longer dates Brad. Eventually, cocaine no longer is doing such wonderful things for Sarah. She becomes irritable, has difficulty sleeping, and uses tranquillizers and alcohol to calm down. Finally, she goes to a professional counsellor who helps her put her life together again. The second filmstrip deals with the physical, behavioral, and social effects of cocaine. Arnold Washton, MD, from the United States telephone hotline, 800-COCAINE, talks about the problems hotline callers reveal.
General evaluation: Good to very good (4.8). This contemporary, well-produced filmstrip illustrates the seductiveness of cocaine and the eventual dangers that ensue from heavy use.
Recommended use: With a resource person, the filmstrips could help teenagers and their parents.

Parents with Alcoholism: Kids with Hope

Number: 747.
Subject heading: Alcohol and the family.
Details: A two-part filmstrip on video cassette, 30 min.
Synopsis: Children who live with alcoholic parents have many problems. They feel compelled to deny there is a problem. Often embarrassed by their parents' behavior, they are afraid to bring friends home; they restrict their circle of friends and become isolated. They see such inconsistencies in their parents that they distrust whatever is said. Many are physically abused. In order to remove themselves from the cycle of self-defeating and destructive behaviors, children of alcoholics must understand the "disease of alcoholism." They must realize they cannot stop parental drinking. They must reach out to others through such groups as Alateen and understand they are at high risk themselves for alcohol problems and should be careful about their own drinking.
General evaluation: Fair to good (3.9). The videotape transfer of a filmstrip is a disappointing use of the video medium. However, the material has good information for children living with an alcoholic parent and could lead to discussion about ways of dealing with the problem.
Recommended use: With a resource person, the filmstrip could benefit children from alcoholic homes and counsellors and adults who work with these children.

The Orientation Film

Number: 745.
Subject heading: Treatment/rehabilitation.
Time: 55 min.
Synopsis: Angie Dickinson narrates this film about what happens to a person who enters an inpatient drug treatment facility. Examples are shown of the medical treatment, individual and group therapy, leisure activities, and some difficulties patients may encounter. The narrator attempts to maintain a low-key, supportive attitude to urge people to enter and persevere in treatment.
General evaluation: Poor (2.4). The film is lengthy and presents too much material. It depicts a specific rehabilitation process and might discourage potential clients from seeking treatment from other kinds of facilities.
Recommended use: With a resource person, the film could be used with health professionals and, with reservations, those entering a similar treatment facility.

Epidemic: America Fights Back: Employee Assistance Program

Number: 741.
Subject heading: Employee assistance programs (EAPs).
Time: 32 min.
Synopsis: Employees with drug abuse problems cost United States industry billions of dollars. Scenes are shown of train accidents that happened because the engineer was drunk. General Motors assembly line workers and the president of Kemper Insurance highlight the losses to industry. Employees who have been helped by EAPs tell what happened before they got help and what is happening now. Firing well-trained employees is not as productive as rehabilitating them.
General evaluation: Good (4.2). The film explains well the cost of alcohol and other drug abuse to industry and could lead to discussion about the need for EAPs.
Recommended use: With a resource person, the film could introduce companies to the EAP concept

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09/line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents $16 per year
US & Foreign Residents $24 per year
Microfiche $24 per year
Air Mail add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians

The Journal, 33 Russell St Toronto, Canada M5S 2S1

ISSN0044-6203 Printed in Canada

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Introductory Addictions Management Course — weekly, from Sept 24-Nov 26, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Ontario Hospital Association Conference: Care for Patients with Alcohol and Drug Problems — Oct 3, Toronto, Ontario. Information: Gwen MacKinnon, education consultant, Hospital Outreach Service, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

American Association for Automotive Medicine Annual Meeting — Oct 6-8, Montreal, Quebec. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Addiction and Family Violence — Oct 18, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Employee Assistance Programs: Recycling Our Most Precious Resource — Oct 24-25, Windsor, Ontario. Information: Ruth Ryan, Iona College, University of Windsor, 208 Sunset Ave, Windsor, ON N9B 3A7.

Counselling Communication Skills Course — Oct 27-31, March 5-April 23, 1987 and July 6-10, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Social Science Federation of Canada Research 86: Health Issues — Oct 28-30, Edmonton, Alberta. Information: Nikki Basuk, director, Research Canada 86, Transport Canada, Ottawa, Ontario K1A 0N5.

15th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology — Nov 2-6, Quebec City, Quebec. Information: Mary Lynn Moffat, CAG/head office, 1080-167 Lombard Ave, Winnipeg, Manitoba R3B 0V3.

Orientation to the Field of Addictions Course — Nov 6-7, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Beyond Mental Disability: Building a National Agenda for Community Support — Nov 12-15, Ottawa, Ontario. Information: Laura Thomson, director of communications, Canadian Mental Health Association, 2160 Yonge St, Toronto, ON M4S 2Z3.

The Children of Alcoholics: A Canadian Conference for the Helping Professional — Nov 16-18, Toronto, Ontario. Information: Children of Alcoholics conference, PO Box 159, Station H, Toronto, ON M4C 5H9.

Event 86 — Skill Development and Training for Employee Assistance Personnel — Nov 16-20, Oakville, Ontario. Information: James Simon, Addiction Research Foundation, Georgian Bay Centre, PO Box 936, 100 Bell Farm Rd, Barrie, ON L4M 4Y6.

Addiction Awareness Week — Nov 16-22, Ontario. Information: Suzin Jackson, chairperson, Ontario AAW planning group, Addiction Research Foundation, 10th fl, 44 Bond St W, Oshawa, ON L1G 1A4.

Health Promotion Workshop —Nov 17-19, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Drug Education Coordinating Council 4th Annual Conference — Nov 20-21, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

Canadian Addictions Foundation Annual General Meeting — Nov 21-22, Edmonton, Alberta. Information: CAF head office, 4254-93 St, Edmonton, AB T6E 5P5.

Wellness Conference — Nov 30-Dec 3, Toronto, Ontario. Information: Lilian Toyich, Ministry of Health, office of health promotion, 8th fl, Suncor Building, 56 Wellesley St W, Toronto, ON M7A 2B7.

United States

Marijuana Dependence: A National Conference — Oct 3-4, San Francisco, California. Information: Raymond J. Brown, marketing consultant, Henry Ohlhoff Counselling Center, 2418 Clement St, San Francisco, CA 94121.

Alcohol-Related Birth Defects: Implications for Policy— Oct 19-21, San Diego, California. Information: Alcohol-Related Birth Defects conference, University of California, San Diego X-001, La Jolla, CA 92093.

National Federation of Parents for Drug-Free Youth 5th Annual Conference, Networking America for Drug-Free Youth — Oct 9-11, Washington, DC. Information: Mary Jo Green, 8730 Georgia Ave, Ste 200, Silver Spring, Maryland 20910.

Northeast Conference on Addictions: The Chemically Dependent Family — Oct 26-29, Albany, New York. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

American Medical Writers Association 18th Annual Conference — Oct 22-25, San Francisco, California. Information: American Medical Writers Association, 5272 River Rd, Ste 410, Bethesda, Maryland 20816.

Improve Your Group Counselling: An Advanced Skill Building Seminar — Oct 28-30, Houston, Texas. Information: Johnson Institute, 510 1st Ave, N, Minneapolis, Minnesota 55403-1607.

The Age of Geriatric Rehabilitation Perspectives and Potentials — Oct 30-31, New Hyde Park, New York. Information: Ann J. Boehme, associate director for continuing education, Long Island Medical Center, New Hyde Park, NY 11042.

sociation of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Nov 3-6, Dallas, Texas. Information: Judith Evans, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Intervention Workshop — Nov 3-6, La Jolla, California. Information: Nomi Feldman, conference coordinator, 3770 Tansy, San Diego, CA 92121.

American Association for Advancement of Behavior Therapy Annual Meeting — Nov 13-16, Chicago, Illinois. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

14th Annual Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Nov 17-21, Boston, Massachusetts. Information: Kristine Niven, administrative associate, Center for the Study of Drug Development, Tufts University, 136 Harrison Ave, Boston, MA 02111.

SECAD XI: Southeastern Conference on Alcohol and Drug Abuse — Dec 3-7, Atlanta, Georgia. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, 11050 Crabapple Rd, Ste D-120, Roswell, GA 30075.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, 1987, Orlando, Florida. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, FL 33069.

National Alcoholism Forum and Medical Scientific Conference on Alcoholism — April 22-27, 1987, Cleveland, Ohio. Information: Forum coordinator, National Council on Alcoholism, 12 W 21st St, New York, NY 10010.

Abroad

Meeting on the Psychopharmacology of Dependence — Oct 16-17, London, England. Information: P.J. Rowden, dept of clinical pharmacology, Wellcome Research Laboratories, Langely Court, Beckham, Kent BR3 3BS UK.

Jornadas de Socidrogalcohol —Oct 16-18, Cáceres, Spain. Information: Pedro Pereira, Unidad de Deshabituación de Alcoholismo, Complejo Sanitario Assistencial Plasencia, Cáceras/Spain.

World Conference on Addiction — Oct 19-25, Vienna, Austria. Information: Barbara Turner, conference coordinator, Bldg D, Ste 120, 11050 Crabapple Rd, Roswell, Georgia 30075.

National Council on Alcoholism Training Institute — Oct 25-29, St Thomas, US Virgin Islands. Information: Leah Brock, affiliate services officer, National Council on Alcoholism, 12 W 21st St, New York, NY 10010.

Alcohol Problems in Celtic Countries — Oct 30-Nov 2, St Peter Port, Guernsey, Channel Islands. Information: P.J. Lemmon, Guernsey Council on Alcoholism, 50 The Bordage, St Peter Port, Guernsey, Channel Islands.

Society for Prevention of Drug Abuse 1st Scientific Congress: Problems of Drug Addiction —Nov 3-4, Warsaw, Poland. Information: Congress organization committee, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warszawa, Poland.

11th World Congress for Social Psychiatry — Nov 6-11, Rio de Janeiro, Brazil. Information: J. Alberto Costa e Silva, Faculdado de Ceîncias Médicas, Hospital de Clinicas, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil.

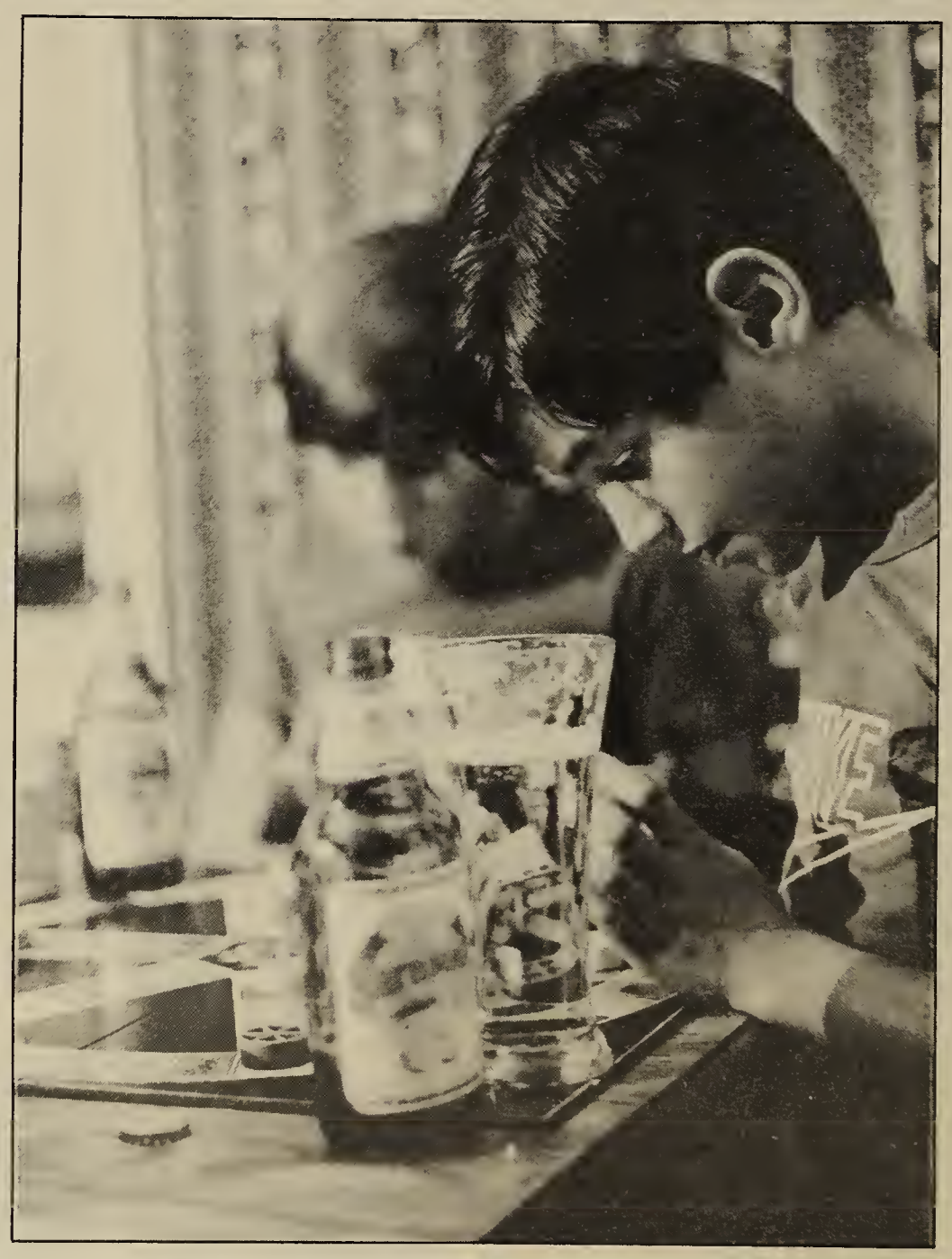
International Federation of Non-Governmental Organizations for the Prevention of Drug and Substance Abuse 8th Annual Conference —Dec 13-19, Sydney, Australia. Information: Chairman, program committee, PO Box 477, Canberra City ACT 2601, Australia.

Symposium on the Prevention of Alcohol Misuse Among Children and Young People — Feb 25-26, 1987, London, England. Information: Institute of Alcohol Studies, Alliance House, 12 Claxton St, London, SW1H 0QS.

7th International Conference on Alcohol Problems — April 5-10, 1987, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

'Coolers' in Canada: public boon or bane?

The corner store debates



By Joan Hollobon

TORONTO — Are low-alcohol 'coolers' a boon to sobriety, or a first signpost to children that alcohol is "cool?"

Sarasoda is described by Labatt's Ltd as "a new sparkling citrus cooler" with "a crisp, tart taste and a small percentage of beer that results in a 0.9% alcohol level."

The brewery claims Sarasoda and similar drinks provide "a safe and sensible alternative to conventional, full-strength, adult beverages," which fit into "today's healthier lifestyle."

Few in the addictions field dispute the benefits of lower-alcohol drinks.

Sarasoda advertising quotes Eric Single, PhD, senior scientist with the Addiction Research Foundation (ARF) in Ontario, recently seconded to the Liquor Licence Board of Ontario: "For adult buyers, ready access to very-low-alcoholic content beverages is very much in the interests of public health."

However, many, including Dr Single, are concerned with the potential for harmful effects, physiological or psychological, on children and youth.

Saskatchewan Health Minister Graham Taylor, in a letter to Allan Phillips, Labatt's vice-president for business development, said he was concerned Sarasoda "muddies the distinction between alcoholic and non-alcoholic beverages" and may act as an "icebreaker to the world of alcoholic beverage consumption."

Similar containers

David Gilbert, executive director of Alcohol and Drug Programs at the British Columbia Ministry of Health, told **The Journal**: "Young people can pick up pop and shandy in similar containers. . . . It seems to promote the idea that it's all right to drink 1% alcohol because you can buy it in the Safeway store."

Labatt's was surprised at the fuss about Sarasoda (see page 1) because similar products — such as Caesar's Coolers — have been on the Canadian market for several years. Sarasoda is still sold only in Ontario, Manitoba, Saskatchewan, and Alberta.

Joanna Fuke, a Labatt's senior brand manager, told **The Journal** that prior to launching Sarasoda, the company distributed information packages to governments in each province, Health and Welfare Canada, consumer and educational organizations, nursing and medical associations, social and welfare workers, AA (Alcoholics Anonymous) groups, and others.

Ms Fuke said great care had been taken in picking a flavor for Sarasoda. When several flavors were taste-tested on volunteers between 16 and 45 years, one was very popular with the youngest tasters: it turned out that it tasted like bubble gum.

"We eliminated that product immediately — the younger they were, the more they preferred it," she said.

The taste decided on for Sarasoda was liked most by adults, least by the youngsters, Ms Fuke explained.

Labatt's also asked retailers not to sell Sarasoda to children and to set a price higher than for soft drinks, she said. (Sarasoda costs 95 cents a 12-ounce bottle here.)

However, there have been reports of young people flaunting their bottles of Sarasoda, beer style, under the noses of teachers.

Robert Simpson, divisional health promotion consultant at the ARF, said one such anecdotal report came from a school in Sudbury, Ontario. And, there was a similar report from Guelph, Ontario, about teenagers aged 12 to 16 years in a shopping plaza using Sarasoda "as an excuse to act a bit crazy," since it is unlikely youth of that age would actually be impaired by one or two bottles.

Student lunches

John Turner, member of the Ontario legislature for Peterborough and Progressive Conservative deputy health critic, first drew Sarasoda to the ARF's attention when contacted by a Peterborough school principal and concerned parents. The teachers had noticed Sarasoda in some students' lunches.

The ARF and the Ontario Ministry of Consumer and Commercial Relations are collaborating on a mailed survey of community police officers, principals of primary and junior high schools (up to grade nine), and medical officers of health to find out the extent of use by children and whether they have seen any problems, such as sickness or unruly behavior. Results are anticipated by year-end.

The ARF's next, regular, biennial school survey will also ask students about use of low-alcohol drinks.

In a preliminary analysis of potential problems, foundation scientists conclude that a 50-pound child theoretically could reach a peak blood alcohol level (BAL) of about 0.015% by drinking quickly on an empty stomach one, 12-ounce bottle of a drink containing 0.8% or 0.9% alcohol.

Since studies have noted discernible effects on adult driving skills at levels as low as 0.015%, the scientists say a small child could be at increased risk in any activity requiring attention, coordination, and judgement, such as crossing a road in heavy traffic, or riding a bicycle.

Mild impairment could be expected at between 0.010% and 0.015%, but would be briefer owing to a child's faster metabolism.

Teenagers would be much less affected physiologically; with them, the major concerns would be defiance of 'no alcohol' school rules and modelling behavior.

In fact, modelling behavior by children and youth of all ages is a major concern everywhere.

Albert Liston, PhD, the federal assistant deputy minister heading the Health Protection Branch, told **The Journal** the branch is currently examining "a data package" submitted by Labatt's.

"We have to determine whether this is the forerunner of a type of product leading to additional non-intoxicating, or less intoxicating, adult drinks, which might have a salutary effect. Or, is it a forerunner of more introductory (alcoholic) drinks for an ever-younger population?" Dr Liston asked.

Fine print

The Canadian Medical Association recommended in August that all alcoholic beverages above the 0.5% level should be controlled by provincial liquor boards (see page 2).

Joan Marshman, PhD, president of the ARF, says many consumers are surprised to discover these 'citrus coolers' contain alcohol because "few people read the fine print."

Unknowing consumption can cause problems for someone taking medication with which alcohol interacts, someone sensitive to alcohol, or for an alcoholic taking disulfiram (eg, Antabuse).

Roland Thibault, general manager of the Yukon Liquor Corporation, reports a complaint from a man who reacts severely to alcohol and who became ill after drinking a cooler believing it was a fruit drink.

Dr Marshman says the pivotal question is whether education through informational material, such as that prepared by the ARF, will be sufficient to ensure consumers can make informed decisions, or whether new labelling requirements are necessary for products available without controls.

Dr Marshman: "Maybe we should be calling these things 'beer coolers' instead of 'sparkling citrus coolers.'"

Low-alcohol coolers and the sale of beer and wine in grocery stores are viewed by many as part of the same spectrum — extending availability of beverage alcohol.

Studies show the easier it is to buy alcohol, the larger the drinking population and the bigger the minority within that population who develop alcohol-related problems; hence the strong opposition which has developed in Ontario and Alberta to demands for extended sale.

A member of the Alberta legislature introduced a motion to permit sale of liquor and wine in grocery stores on the grounds rural people often have to drive up to 30 miles to a liquor store and that it would help the survival of stores in small communities that have economic problems.

Greg Stevens, a member of the legislature and chairman of the Alberta Alcohol and Drug Abuse Commission, objected to the proposal saying Alberta already has one of the highest per capita consumption levels in the world, and this "inescapably means the highest problem levels as well, from impaired driving through to wife and child abuse."

Fabric of life

Mr Stevens told **The Journal** that, indeed, tourists often have difficulty finding out where to buy alcohol, and the province should do a better job of identifying liquor outlets for them. But, he said: "I hate to see us change Alberta's fabric of life simply because some tourists cannot find the liquor stores."

Drinking and driving was also a concern of Ontario member of parliament John Turner.

"It seems to me ludicrious that we should consider making beer and wine more available at a time when everyone is speaking out against drinking and driving," he said.

National roundup

THE BACK PAGE

Vol. 15 No. 11 2nd Class Mail Reg No. 2776 TORONTO, November 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Explosion of chemical knowledge creates new genus

'Orwellian' drugs demanding attention

By Harvey McConnell

WASHINGTON — A genus of drugs which can make people work longer, learn more quickly, or alter moods without side-effects is eagerly being pursued by the world's pharmaceutical industries.

The explosion of knowledge in recent years about brain chemistry is being harnessed in a search for drugs which can exploit such chemistry in people who are not dysfunctional.

The implications for what many would consider Orwellian opioids make today's problems with illicit compounds (**The Journal**, January) pale by comparison.

Society, in the real sense of drug prevention, must start to debate whether these drugs, with the enormous implications of their use, should even be allowed. It is, perhaps, fatuous to think the pharmaceutical industry or the medical profession, given the history of psychotropic drugs (**The Journal**, July), could or would exercise self-restraint.

An almost lone voice at the moment is Charles Schuster, PhD, director of the United States National Institute on Drug Abuse (NIDA). He told **The Journal** it is vital to develop social policies now, before the drugs start appearing.

Dr Schuster: "We obviously need drugs to eliminate suffering. The question really is, do we need drugs that might enhance performance?"

Does society want a drug children could take every day to enhance their learning capabilities, one that would allow a person to work two or three hours longer during the day, or one that would improve mood without toxic effects?

The questions are not hypothetical: the US military, for example, is interested in development of drugs to allow pilots, under emergency conditions, to be able to continue to function safely for an extended period of time.

Dr Schuster says every time a little more is discovered about the neurochemistry underlying mood, the basis of mood states, cognition, and the neurochemistry underlying behavior, there is potential for developing new, subtle-acting psychoactive drugs.

"We open the way for new drugs that are going to produce very profound effects."

Dr Schuster: "There is absolutely no question of the fact that if we are going to talk about drug abuse, we have to think not only of the drugs available right now, not only of the drugs which are being developed by underground chemists — the controlled-substances analogues — but also, of the drugs the pharmaceutical houses are developing.

"I think we really have to have a federal policy. People in the US have to start thinking about the issue: mind-altering substances are going to increase in number."

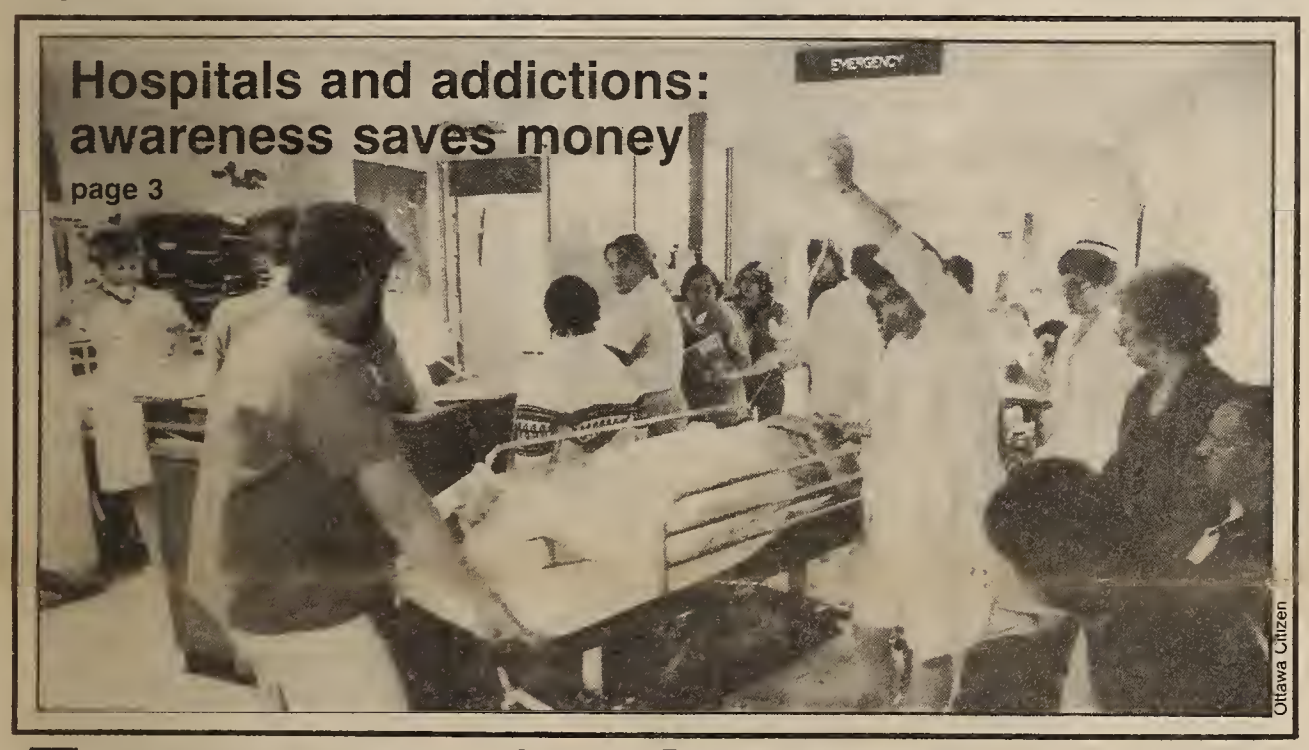
It is impossible to determine at present whether or not the new genus of drugs will be beneficial.

Dr Schuster: "There is no question, in my opinion, that we currently do not have good medication for many psychiatric disorders. Clearly, we need these.

"The question then becomes. 'Should we develop drugs that can enhance normal performance?' It is conceivable that a drug could be developed that does not have some of the deleterious consequences of current stimulants.

"I don't know whether we want it or not. But, I think we have to start realizing it is well within the range of possibilities."

Dr Schuster says once these drugs are developed and used, even under limited circumstances, "it is going to be impossible to keep them out of the hands of the public."



Ottawa Citizen

Hospitals and addictions: awareness saves money
page 3

European legislators outline prevention plans

By Harvey McConnell

LONDON — A proposed United States-style drug task force and tough regulations on banks and chemical companies, coupled with determined prevention and rehabilitation programs, have been put before the 12-nation European Parliament.

Although a 16-member Euro-parliamentary committee, which produced the drug report, agreed on most points, a five-woman minority from far-left parties instead called for legalization of all drugs (see page 2).

The debate was spearheaded by British European member of parliament Sir Jack Stewart-Clark (**The Journal**, September) and David Mellor, British Undersecretary of State at the Home Office and chief British government spokesman on drug issues.

The year-long study leading to the report included rafts of testimony and visits by some committee members to the US.

The report concludes members of the European Economic Community are unable to cope with a rising heroin problem and are even more unprepared for an expected invasion of cocaine (**The Journal**, September).

One of the major features of action would be a US-style drug task force which would link the police, customs, and other agencies in the community in a combined effort against trafficking.

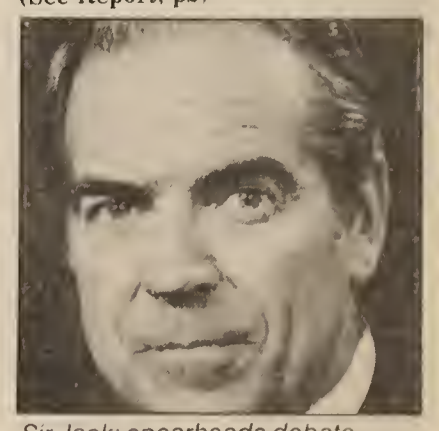
In an attack on European bank secrecy, the report said: "Every financial institution should be aware it is a potential target for money laundering by criminal organizations and that participation in laundering operations will have serious legal consequences." In addition, there should be a reporting system as in the US for all cash transactions above a certain amount.

On the question of chemicals from companies in Britain, West Germany, Holland, and Italy finding their way to trafficking laboratories, the report said a list of the most dangerous chemicals should be drawn up and an informal monitoring system instituted. Any suspicious purchases of the relevant chemicals should be reported.

Family doctors should be in the front line in treating addicts and should be given training on drugs, drug abuse, and the resources available to cope.

On the prevention side, the report said as supply reduction in the short-term is unlikely, demand reduction should be a major objective.

(See Report, p2)



Sir Jack: spearheads debate

Epp zeros in on Canada's strategy

National drug policy awaits provincial input

By Elda Hauschildt

OTTAWA — The outline of a proposed Canadian national strategy on drugs took some form in a House of Commons statement here by Health Minister Jake Epp.

But, addiction workers still have to wait further for details.

Mr Epp's statement in October was the third public reference to a national drug policy in a one-month period, indicating the drug problem has moved up on the federal government's priority list.

Prime Minister Brian Mulroney first talked of a national strategy in September (**The Journal**, October), and the government referred in general to action against drug trafficking in its October 1 Speech from the Throne opening Parliament.

Epp: consensus

In his statement, Mr Epp, too, spoke generally about policy: "The problem of illicit drugs is more profound because of international networks, the hidden character of drug marketing, and the enormous risks of drug dependency, medical emergency, and death."

But, he did pin down three "components" of a national strategy:

- federal leadership to bring the provinces and communities together to work on demand reduction,
- increased efforts to stop the production and distribution of illicit drugs, again through demand reduction programs, "public awareness, education, research, and a variety of provincial activities," and
- international participation in supply reduction, including Canada's signing of the 1971 international Convention on Psychotropic Substances (**The Journal**, June).

A national strategy (**The Journal**, May), Mr Epp promised, will be delivered "later this session," and drug abuse will be on the agendas of two federal-provincial ministerial conferences, on health and social services, later this fall.

"The government intends to follow a timetable that recognizes the involvement of other players in this important issue, particularly the provincial governments. We do not intend to move without thinking through the best possible approaches. We do intend the strategy to be backed by consensus among experts and by resources," said Mr Epp.

The consensus, his drug policy adviser Pat Thompson told **The Journal**, is the "lynchpin" of the strategy, and until federal-provincial and community consultation takes place "in the months to come," details of the strategy won't be available.

(See Public, p2)

INSIDE

NEWS

Briefly . . .

Papal foam furor

SYDNEY — The local aboriginal community here is embroiled in a bitter dispute about brewery sponsorship of an upcoming papal visit. The South Australian Brewing Holdings Group, which is sponsoring a segment of the Pope's tour this month, will also issue special edition beer cans to commemorate the visit, *Reuter* reports. The head of the Aboriginal Affairs Department, Charles Perkins, asked tour organizer Reverend Anthony Kain: "Why don't you get sponsorship from cocaine and heroin dealers . . .?" Mr Perkins was particularly incensed at Rev Kain's remark that alcohol is a gift from God.

Surinam bypass

MIAMI — A United States federal jury has convicted a top Surinam military official and two associates of offering their South American country as a way station for US-bound cocaine, at a price of $1 million per shipment. *Associated Press* adds the three were convicted of conspiracy to import cocaine, and travel in furtherance of the conspiracy.

Smoky jails

TORONTO — Teenagers are given free tobacco when they enter Ontario jails and prisons, although a provincial act says no one should furnish tobacco to those less than 18 years. *The Globe and Mail* reports inmates who can't afford cigarettes get free tobacco at detention centres, while prisoners at correctional institutes buy their cigarettes at reduced rates. A spokesman for the Non-Smokers' Rights Association says he's heard accounts of youth who "went into jails non-smokers and came out addicts."

Fetal abuse

SAN DIEGO — A woman whose son was born brain-dead, with amphetamines in his system, will face a jail term of one year if convicted of contributing to his death by taking drugs during pregnancy. The San Diego County district attorney's office admits it's entering new legal territory, but contends the mother is criminally liable for her son's death, says *Associated Press*.

Diverting customs

TORONTO — Drug smugglers are getting jobs at Canadian airports or bribing employees to let illegal drugs into the country, says *The Globe and Mail*. Cleaning staff, ramp workers, cargo company staff, caterers, and airline employees are suspected of removing drugs from shipments before they reach customs' offices and of diverting shipments and baggage away from customs' areas.

Seal of disapproval

LONDON — The British Medical Association wants bigger, bolder, and blunter anti-smoking messages printed on every package of cigarettes, says *Doctor*. They say the warning should form a seal, across the lip of the packet, which would have to be broken before opening.

US survey shows 80% of coke users have tried intravenous administration

By Harvey McConnell

WASHINGTON — Cocaine use in the United States continues to rise, as does the number of people who report serious problems with it.

At the same time, use of marijuana, LSD and PCP, and other drugs continues to decrease, says the US government's eighth national household survey on drug abuse. The survey has been carried out periodically since 1971 by the National Institute on Drug Abuse (NIDA).

In overall terms, 36.8 million people age 12 years or older reported having tried marijuana, cocaine, or other illicit drugs at least once in 1985, and 23 million report having tried illicit drugs at least once during the month prior to the survey.

The number of current cocaine users climbed to 5.8 million in 1985, compared with 4.2 million in 1983.

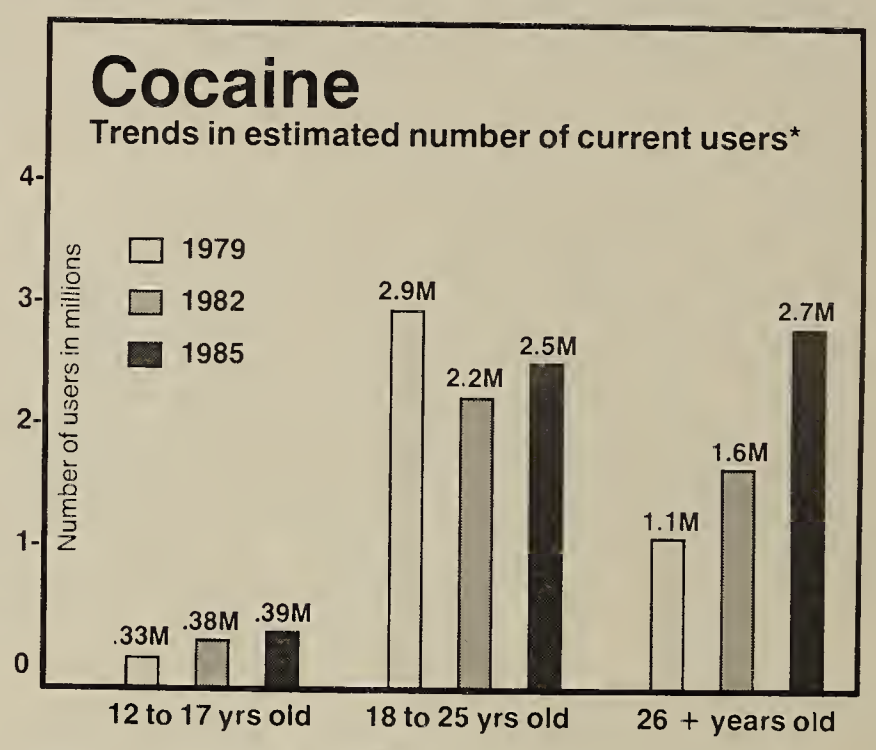
At a press conference, Ian Macdonald, MD, administrator of the US Alcohol, Drug Abuse and Mental Health Administration, said one of the most interesting findings is the route of administration of cocaine.

Virtually all cocaine users (95%) have tried snorting the drug. Experts are particularly concerned about the 80% who have used the drug intravenously, because of the threat, through needle sharing, of AIDS (acquired immune deficiency syndrome), and the 21% who smoked freebase forms of cocaine.

Dr Macdonald: "Especially disheartening is the finding that 44% of youth who have used cocaine have smoked freebase. For young adults, this number is 21%, and for those 26 to 34 years old, it is 19%."

Dr Macdonald said those reporting marijuana use in the past month decreased to 10% in 1985, compared to 11% for 1982.

"Even though there was an overall decrease in marijuana use, we are disheartened to find six million people reported they use marijuana almost daily.



*People who used cocaine at least once in the month prior to interview
Source: NIDA, National Household Survey on Drug Abuse, 1985

"Among youth ages 12 to 15, 23% of males and 10% of females who have tried marijuana had used it at least 100 times.

"Among young adults aged 18 to 25, there was an even higher percentage: 39% in males and 24% in females who tried marijuana used it 100 or more times."

The survey found more than 60 million people are current cigarette smokers, and the relationship between drinking, smoking, and the use of other drugs is marked.

Dr Macdonald said the survey shows "in many ways, we are making progress in the fight against drug abuse. However, we have a very long way to go."

He added that the statistics on cocaine use and the number of users seeking treatment show "it is very difficult for a user to control, and more and more of those who have been users will need treatment."

Charles Schuster, PhD, NIDA director, said the institute is now carrying out a number of research initiatives on cocaine.

He added that while the focus is on cocaine, "we don't want to neglect the continuing problem of marijuana or the continuing problem of heroin addiction, even though there may be national emergencies associated with a particular drug."

Report puts Europe on drug 'warpath'

(from page 1)

"Education of children, parents, teachers, and professional workers at all levels is the key to reducing demand."

Andrew Pierce, British Euro-MP on the investigation committee, told a press conference the actions "are in effect putting the European community on the warpath against this problem by bringing in a whole new set of actions to catch traffickers and to deal with the problems of addicts in a humane way."

He noted while most socialist members of the parliament were not in favor of legalization, the members of the committee who disagreed with the report (see Minority, below) said they wanted drug "liberalization" and "normalization," which can only be interpreted as legalization.

Sir Jack, who visited all member nations to talk to government officials about the report before the debate in the parliament, said if an informal monitoring system for export of chemicals does not work, "there would be mandatory controls further down the line."

He said it has to be remembered that there is the 'Portuguese Connection' between Portugal and Brazil and the 'Spanish Connection' between much of Latin America and Spain.

As for the call for liberalization, Sir Jack pointed out that the Netherlands received a shock when drugs were made freely available some time ago.

Today, the administration in Amsterdam has made a determined effort to clean up the city (**The Journal**, October), and things have changed significantly in the past five years.

The proposal on the treatment side calls for the issuance of clean needles for intravenous users.

On prevention, the entire parliament is in agreement on more money for education in every school in every country. "They need to learn there is something called drugs, and they are dangerous," said Sir Jack.

Sir Jack and the rest of the parliament realize none of their short-term actions will solve the problem: their main hope is "to keep the drug traffickers off balance enough" and to delay widespread availability of cocaine.

Minority group backs legalization

LONDON — Five far-left members of the European Parliament, all women, issued a minority report claiming the majority findings did not reflect adequately different views expressed at the hearings.

The minority report said that instead of simply combating drugs, "the main aim should be to normalize society's approach to drugs, drug use, and, regrettably, drug addiction.

"This means comprehensive measures in rehabilitation, training, and education."

In its most controversial proposal, the minority report declared that "repressive measures" had not worked in stemming the drug trade. The report called for a hearing by November, 1987 to study at the European-level, "the legalization of drugs in order to eradicate drug trafficking, stabilize the market for these products at a much lower controlled price, and to make the products marketed subject to health inspection, in short to adopt an anti-prohibitionist policy associated with a vast information campaign on the risks involved in drug taking."

Public education urgent

(from page 1)

Mr Epp told the Commons the drug problem is not "reflected uniformly" across Canada.

"Chronic unemployment and family pressures in some communities have produced or exacerbated drug abuse. Victims in such cases as these are victims in a much broader sense," he said.

He said the planned strategy the government has been working on since the spring will "attack this urgent problem" methodically and in keeping with the "Canadian way" of responding to social needs.

Mr Epp: "It is the Canadian way to deal with a problem like drug abuse by emphasizing public education and awareness, rehabilitation of victims, and primary prevention of demand as well as to rely on law enforcement and legislative measures to curtail supply."

Legislative changes foreseen under the national plan will "consolidate and modernize the legislation underpinning of our enforcement efforts," said Mr Epp

"Some of these changes would enable us to respond more swiftly to rapid changes in the drug market. This would give us a basis for dealing more effectively, for example, with the problem of designer drugs" (**The Journal**, January).

NEWS

Hospital awareness of addictions saves money

By Joan Hollobon

TORONTO — Alcohol and other drug problems are related to one-quarter to one-half of all hospital admissions, resulting in "phenomenal" costs.

Therefore, raising awareness of addictions among hospital staff is essential, Maris Andersons, MD, told an Ontario Hospital Association conference here on care for patients with alcohol and other drug problems.

Dr Andersons, chief of staff at the Donwood Institute here, said one in five or six of the patients seen by the average family doctor is likely to have an alcohol or other drug problem.

Yet, "speaking as a physician, the training I had (on addictions) was pretty limited."

Medical education is improving, with "a real change" in Ontario medical schools even in the past two years, he said.

Joan Marshman, PhD, president of the Addiction Research Foundation (ARF) here, said as far back as 1969, former Ontario minister of health Thomas Wells recognized general hospitals as "an essential and important" part of the treatment of alcohol and other drug addictions." With notable individual exceptions, however, the hospital community as a whole in Ontario has not "enthusiastically embraced this role."

Dr Marshman drew attention to the costs in dollars and human suffering related to alcohol use.

"What we are talking about in total is that at least 6% to 7% of our adult population, and perhaps as high as 12%, fall into this composite category of alcoholics and drinkers at risk."

These people become part of the general hospital population with a wide range of health problems, some with alcohol-specific problems, such as alcoholic psychoses, alcohol-dependence syndrome, non-dependent use of alcohol, toxic effects of alcohol, and chronic liver disease and cirrhosis (**The Journal**, November, 1985). In 1983-84, Ontario hospitals reported 30,000 such inpatient admissions.

For the first four conditions alone, this translated into a cost of about $63 million in 1983 dollars. Treatment of chronic liver disease and cirrhosis added a further $17 million to $27 million, for a total estimated between $80 million and $90 million, Dr Marshman said.

A United States study shows 72% of patients with a primary diagnosis of alcohol abuse had at least one additional disorder, the most frequent being diseases of liver or pancreas, poisoning by psychotropic or other agents, head wounds, and gastrointestinal bleeding.

In addition, alcoholics often stay in hospital longer and use emergency services more than others, particularly for injuries.

Dr Marshman said ability to predict which departments are most likely to encounter alcoholic patients can help hospitals plan constructive action.

In 1981 dollars, it has been estimated alcohol costs society some $1.6 billion in excess health care, lower productivity, accidents, policing, social services, and the like. This is more than two times the $0.7 billion in revenue from alcohol.

The burden on the health system can be reduced by treatment and, even more, by prevention, Dr Marshman said.

Nath Nayar, MD, president of the Donwood Institute, said "rightly or wrongly," primary physicians have been identified as one major stumbling block in diagnosis and treatment.

Few of the 20% to 30% of hospital

Marshman: composites

patients with alcohol-related problems are referred to specialized treatment centres. One recent study found while 78% of the patient sample abused alcohol and 85% of these abusers had discussed alcohol with their physicians, only 21% were sent for consultations.

Dr Nayar: "It is unrealistic to expect general practitioners to respond enthusiastically to the task of detecting and managing alcohol problems, while political and economic interests sustain public belief and attitudes toward drinking and make it difficult for doctors and patients to acknowledge the existence of such problems."

Len Hargot, MD, associate professor of family medicine at McMaster University, Hamilton, urged hospital staff to become more sensitive to indications of alcoholism. Help could then be extended when patients enter the emergency department in a crisis situation, "when we might be able to influence their lives."

An Ontario profile

Drinkers' health care costly

TORONTO — Alcohol-related health costs now total almost 10% of Ontario's health care budget, says Joan Marshman, PhD.

And, that budget totals approximately $10 billion, Dr Marshman told an Ontario Hospital Association conference here. (see above story).

Eighty-four percent of all Ontario residents older than 18 years (87% in Metro Toronto) drink alcohol "at least occasionally," said Dr Marshman, president of the Addiction Research Foundation (ARF) here.

In 1981, the ARF estimated 3.6% of the adult population of Ontario "was without question, alcoholic." Figures for 1983 suggest a slight drop, to about 3.2%.

While the mean level of drinking is two drinks a day, 49% of all drinkers report they consume five or more drinks at a sitting, an amount capable of producing a blood alcohol level (BAL) detrimental to physical, social, or mental well-being, or all three.

Those who sip all day, consuming an amount far in excess of two drinks but without ever reaching a high BAL, also pay a price in health problems.

The numbers of alcoholics are equalled, if not exceeded, by drinkers whose consumption exceeds the "breaking point" of 14 drinks a week, beyond which alcohol-related health problems increase.

In 1983/84, 6,300 deaths in Ontario — close to 10% of all deaths — were alcohol-related.

INSIDE OUT

A hero fit for me

It was one of those days, because it was one of those nights: I was walking down the street, early in the evening, and I was sinking very fast and very deeply into depression.

It had come out of nowhere, this "black dog" as Churchill called it, and he had had to fight it heroically all his days.

There is nothing I can recall that had made it bloom so evilly. There I was, as the late summer sun started to go down, and I was lost, staring blankly at blank-looking people who walked by me without any decipherable purpose, that I could see, to their lives.

And suddenly I seemed so useless, too. All the goals I'd so meticulously crafted in optimistic moments, and there had been many blessed ones since I stopped drinking, were like a fragile, laughable house of cards. I was spinning my wheels, going nowhere, waiting, really, for some ignominious, dull end to my time here.

Who was I kidding anyway? What real 'progress' had I made? I still had so many obvious inadequacies. I felt like Sisyphus, condemned to push the stone of my failures and lacks and defects up that meaningless mountain forever.

There was never any way, it seemed to me as I stood in the street, that I was going to become the man I wanted to be. My past prevented it. It pulled me down too often, too harshly, it teased me with the thought of better days; and then, it yanked them from my grasp like a cruel adult withholding a bone from a trusting dog. And everyone knows trusting dogs can go crazy and violent if they're denied too long.

I stopped by a pay telephone. I was ready to call a friend, indeed anyone now, because I could feel the panic coming. It was a complete panic: I hadn't felt like this in a long time; it was the panic I'd had before almost going under permanently about two years ago.

But, of course, I was too stubbornly stupid, too haughty — my friends kept telling me how proud they'd become of my journey toward wholeness, sometimes I was even arrogant enough to think they envied me — to shatter their new notions of me. When you spend a lot of time projecting to others that you're in control now, that you've entered what seems to be a permanent safety zone, you shy away from lowering the guard a little, when you really need to talk to someone about how sometimes it gets hard, so damned hard, merely to make it through a day.

Sometimes, a stiff upper lip will get you a broken jaw: we are made to bend and

From this ignored, humble, rag-tag band of losers came wisdom and caring and love

adapt, to roll with all the punches; we are made to help and love each other; we were not made to do it all by ourselves, only for ourselves. No, damn it, I'll help you, if I am able, and you help me too.

So, all I could think of, at that hour, under those circumstances, on that Saturday night, was AA, good old Alcoholics Anonymous. I'd only been about five times, three because I'd been strongly advised to attend back in my pioneering days of being sober. I had been strongly impressed and moved, too, but not enough to make it a habit, another addiction, if you will.

But, I didn't want to be alone this night. I couldn't be alone; I dared not be alone.

I called the main AA number, found a place nearby. I even shaved and put a tie on, and I headed into the worst part of the city, where I spend my time these days.

The meeting was in a church in a poor housing project and on the way there, I saw drunks weaving like wheat on windy days, I saw hookers screaming at each other, I saw obviously mentally handicapped people — one weeping, alone, in a corner — stumbling toward me, their eyes either dull or full of terrifying fear. I saw a fight, I saw a woman crying by herself at a streetcar stop.

Inside the church, down in a basement (will they ever hold an AA meeting on the 17th floor?) the troops were gathering.

This was to be, I quickly assessed, no assembly of yuppie alcoholics. No, sir, these were authentic street people: you could see the scars, they were like badges they wore. The talk was almost inarticulate, too: monosyllabic, gruff, almost like concrete poetry.

I felt not at all at home, to tell you the truth. These were not my kind of alcoholics; there was nothing here for me that I could connect with, nothing at all. These people were losers . . . .

The man I sat next to — I called him the Joker — kept laughing in all the wrong places; he made gigantically silly comments. One man shook all over, another had just gotten out of jail. The man who was chairman seemed consumed by barely controlled violence, and a sad woman, hooked on drugs and booze she said, added she was having a terrible time trying to reach out to anyone. She couldn't even reach out to the people here, she went on.

Outside, an ambulance screamed its way through the night. Children looked down at us from above through the basement window; they giggled and laughed at us, and it seemed appropriate.

A young woman came in late. She was in sad shape. I thought she was drunk, or stoned. She wore dirty jeans, her hair was dirty too; her eyes had that peculiar depth of someone who's been beaten down once too often, and she had a black leather jacket on. She sat down between an older couple: the man weighed about 300 pounds, the woman was not so large, but she was getting there.

And then the most amazing things happened.

From this ignored, humble, rag-tag band of losers came wisdom and caring and love.

The young woman, her eyes popping, was hugged repeatedly by each of the older couple. They kissed her, they stroked her hair, they laughed with her, they calmed her down.

I was sitting behind them, and the Joker was right behind me, still laughing in the wrong places. I heard him tell someone else he was a manic-depressive and had no money for lithium to calm him down. I heard him say he'd lost his job, his family, but he was still straight now. He was fighting as hard as he could to hold on, to hang in, and he got up to say the *12 Steps* and suddenly, he was noble for an instant. I saw how much pain he was in as he read; he was making an heroic effort of his own, a Churchill of humble proportions he was, and my heart went out to him, all the way out to him.

I was called on to read, too, about the requirements for being a member of AA. And can I tell you now that being asked made me proud, prouder and more grateful than almost anything else I'd done in months?

The speaker for the night was the young woman. I was stunned. She was obviously out of it: why was she going to tell us her story? It seemed a cruel joke.

She was magnificent. She was almost blind, she was becoming deaf. She'd just gotten out of a hospital after an operation, she wasn't feeling well, and this was her first time as a speaker anywhere. She hemmed, she halted. She told her story with alcohol; she'd been sober four years.

My shoulders started to shake. I felt ashamed of myself, to see her struggling to survive, to see her trying so hard.

But later as I walked out of that basement, feeling better now, definitely feeling connected, feeling humility — a good healthy humility — I looked back at that young woman, and I said to myself: you are a hero fit for me.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Unwrapping a padded 'high'

An unlikely product, adhesive tape remover pads, has been identified as a potential source of solvent abuse. Thomas Zipp, MD, a Cleveland physician, reports the case of a 36-year-old patient undergoing regular hemodialysis who made frequent and demanding requests for the tape remover in order to clear her skin of adhesive tape used to hold needles in place. As a family member reported to Dr Zipp, the patient "was inserting adhesive tape remover pads in her nostrils." Dr Zipp says the pads, often supplied to hospitals in the form of individually wrapped, impregnated units, contain either perchloroethylene or 1,1,1-trichloroethane, the same active ingredients found in typewriter correction fluids, another source of solvent abuse. "Because of their convenient method of packaging, the pads represent an attractive alternative to solvent sniffers," says Dr Zipp, adding that hemodialysis units should be especially aware of the problem.

The Journal of the American Medical Association, July 4, 1986, v.256:39-40.

Early clonidine research validated

With a larger patient sample, a team of Connecticut physicians confirmed their 1982 findings that a combination of clonidine (eg, Catapres) and naltrexone can rapidly, safely, and effectively treat patients being abruptly withdrawn from methadone maintenance. Drs Dennis Charney, George Heninger, and Herbert Kelber, from the Connecticut Mental Health Center and the psychiatry and laboratory medicine departments of Yale University School of Medicine, both in New Haven, tested this treatment protocol in 40 hospitalized, methadone-addicted patients. Patients were abruptly withdrawn from methadone and treated during a four- to five-day period with the clonidine dose determined by the severity of both the withdrawal symptoms and the drug's side effects. The dose of naltrexone was gradually increased from one milligram per day to 50 mg per day during the treatment period. The researchers found 38 of the 40 patients successfully completed the treatment and were discharged. The other two patients were later successfully treated with clonidine alone. Symptoms such as anxiety, anorexia, insomnia, and muscular aching were not totally eliminated during the withdrawal period but were mild or nonexistent by time of discharge. The report concludes the five-day treatment regimen "should enable most patients to abruptly discontinue at least moderate doses and duration of methadone treatment. Patients can then be discharged on doses of naltrexone sufficient to antagonize the effect of exogenous opiates and on low doses of clonidine to effectively control withdrawal symptoms."

American Journal of Psychiatry, July, 1986, v.143:831-837.

More psychiatric patients smoke

Psychiatric outpatients have been shown to smoke significantly more than their peers of the same age and socio-economic standing. An evaluation of the smoking status of a group of 277 outpatients from a general psychiatry clinic at the University of Minnesota Medical Center, Minneapolis, was undertaken by researchers there. To compare smoking rates, they also looked at two control groups: random samples of 1,440 Minnesotans and 17,000 United States citizens. Overall findings were that 52% of the psychiatric outpatients smoked, compared to 30% of the Minnesotans, and 33% of the national control subjects of the same age, sex, marital status, socio-economic status, and alcohol use. Smoking was found to be especially prevalent among schizophrenic and manic patients who had smoking rates of 88% and 70% respectively. Researchers say the higher smoking rate couldn't be linked to excessive coffee drinking because the patients drank less coffee than the controls. They say there are several untested hypotheses to explain why the psychiatric patients smoked more: they are bored and tend to smoke more for this reason, they have behavioral or psychiatric symptoms that may be relieved by smoking, or they are just more likely to become dependent on drugs. No matter what the reason behind the finding, the researchers conclude, psychiatrists must become more involved in advising patients to stop smoking.

American Journal of Psychiatry, August, 1986, v.143: 993-997.

Baby born intoxicated

The case of a mother who abused alcohol to such an extent her baby was born drunk has been detailed by a British physician. John Beattie, MD, of City Hospital, Nottingham, reported that the 29-year old mother, who had a history of chronic alcohol abuse, was drunk and uncooperative when she arrived in advanced labor at a hospital in Scotland. While the delivery was normal, both the infant and the placenta smelled strongly of alcohol, and the boy had a blood alcohol level of 0.212%. A similar level was recorded for the mother, Dr Beattie said. While the mother was virtually alcohol-free 12 hours post delivery, the infant took twice as long to clear his alcohol load. And during the first two days, he had symptoms such as tremor and irritation suggesting acute alcohol withdrawal. Three years of follow-up indicated the infant had a normal growth velocity, gross motor skills, and language attainment, but his fine motor performance was poor, and he continued to have a smaller than normal head circumference. While heavy prenatal alcohol exposure was documented, the boy showed no specific facial features consistent with fetal alcohol syndrome. Symptoms were more compatible with the less specific diagnosis of fetal alcohol effects.

Alcohol and Alcoholism, No. 2, 1986, v.21:163-166

Pat Rich

Lung cancer hits women sooner, whether they smoke cigs or not

By Deana Driver

SASKATOON — Lung cancer may be a sexist disease, new research indicates.

A study conducted by Helen McDuffie, PhD, Jim Dosman, MD, and David Klassen, MD, through the Saskatoon Cancer Clinic and Centre for Agricultural Medicine at the University of Saskatchewan here suggests lung cancer attacks women sooner than men, whether they smoke or not.

The study examined 927 lung cancer patients in Saskatchewan, 197 of whom were female. Women were diagnosed for lung cancer at an earlier age than males (63 years compared to 67 years) and were significantly more likely to be lifetime non-smokers of cigarettes than male patients (23% vs 3.7%). Forty-two per cent of women were diagnosed before age 60 years, while only 25.6% of men were.

An interesting difference in sexes shown by the study is that women started smoking at an older age (19.5 years vs 16.5 years), smoked for fewer years (41 years vs 47 years), and smoked fewer cigarettes a day (23.8 vs 26.7) than male patients. Similar results were found for the duration of the smoking habit and number of cigarettes smoked among ex-smokers, said the researchers.

"When current smokers and ex-smokers were combined, the distribution of patient pack years by gender was significantly different." (Patient pack years refers to the cigarettes smoked per day, divided by 25, times the number of years the patient has smoked.)

The researchers conclude endogenous factors may contribute to the development of lung cancer in women, a startling discovery, says Dr McDuffie.

"Women previously didn't have too many occupational exposures. Not too many of them smoked, so the professionals thought maybe women would be less susceptible to smoke. It's frightening when you think young girls today start smoking at age 12 years."

The researchers also found farmers are more prone to developing lung cancer than people in other occupations. Comparisons of 730 male lung cancer patients and 768 male controls in Saskatchewan, about half of whom farmed for 10 years or more, show the patients to be more frequently exposed to fungicides and grains, and to have worked in a mine. They developed bronchitis, emphysema, pneumonia, farmer's lung disease, and heart disease more frequently than control subjects and had more injuries to the chest or neoplastic disease.

There were more current smokers among these patients and patient pack years were higher than for control subjects. But, of the 26 lifetime, non-smoking patients, 19 were farmers, compared to the expected number of 12.6 cases. This suggests a risk due to farming practices which is independent of smoking, say the researchers.

Susceptibility: 'frightening'

CRTC formalizes rules

Self-regulation on drink ads denied

By Elda Hauschildt

OTTAWA — The Canadian Radio-television and Telecommunications Commission (CRTC) has decided to retain its pre-clearance of beer, wine, and cider advertising instead of allowing self-regulation by the Canadian Association of Broadcasters (CAB).

In its mid-September decision, the CRTC said the ruling was based partly on negative public response to the proposal (**The Journal**, June) and partly on evidence at its May hearings of "fundamental differences between broadcasters, brewers, and advertising representatives as to how the (self-regulation) code should be administered."

The elements needed "to ensure successful self-regulation are not sufficiently apparent at this time," the CRTC ruled.

The self-regulation proposal was made by the CAB last March; the CRTC held public hearings here in May, receiving 116 submissions, and hearing from 31 interested groups.

The CRTC decision also:

- modified the guidelines used for advertising pre-clearance, giving them the force of law through a new Code for Broadcast Advertising of Alcoholic Beverages;
- modified the rule against celebrity endorsement in radio and television commercials to disallow only endorsements by celebrities likely to be role models for young people; and,
- gave permission for commercials for other alcoholic beverages containing no more than 7% alcohol by volume. This allows ads for liquor- and beer-based "cooler" products (**The Journal**, October) to be broadcast; wine-cooler ads were already allowed.

The new CRTC code retains bans on advertising spirits and on showing the consumption of alcoholic products; it adds a formal prohibition against associating motor vehicles and alcohol.

US bank raises prevention funds

By Harvey McConnell

BOSTON — The Bank of Boston, one of Massachusetts' main financial institutions, has linked up with Governor Michael Dukakis in an unusual program to raise funds for an upcoming, five-year drug abuse prevention program for state schools.

Mr Dukakis and bank officials announced at the North American Congress on Alcohol and Drug Problems here that from October to December the bank will allocate one cent from every Mastercard and Visa credit card transaction made by its approximately 750,000 Massachusetts' credit card holders. The bank will also contribute $21 for each of the first 5,000 credit card accounts opened during that period.

The funds will be used to produce teacher training materials being developed by the governor's drug prevention program.

Dukakis: begin early

Mr Dukakis told the congress there must be a long-term commitment to prevention efforts: "If all we're talking about is a six-month public relations campaign, forget it. In Massachusetts, we're planning a five-year program, and we'll be monitoring our progress carefully."

Mr Dukakis emphasized curriculum programs on drugs must begin as early as kindergarten and continue through high school for every student in the state.

At the same time, he called for schools to redraft their discipline code to deal specifically with cases of alcohol and other drug abuse and the possession and sale of drugs in and around the schools.

"There should be a drug- and alcohol-free zone around every school."

Mr Dukakis said his state has encouraged and helped every community develop and sign a written memorandum of understanding between the school superintendent and the local police chief outlining procedures each will follow to deal with students caught using and selling drugs. A process for school/police cooperation in these matters has also been set out.

The governor said a good proportion of the needed funds should come "from federal drug forfeiture proceeds that are not being plowed back into the enforcement effort."

NEWS

Despite public concern in the 1970s

Benzodiazepines still being widely prescribed

By Lillian Wylie

VANCOUVER — Despite the hue and cry about diazepam (eg, Valium) in the 1970s, large amounts of benzodiazepines are still being prescribed in this decade.

Who are the users?

Mostly women, says Susan Penfold, MD, psychiatrist and author, now chairing the women's studies program of Simon Fraser University, Burnaby, BC (**The Journal**, July).

In fact, studies consistently show women receive twice as many mood-altering drugs as men. A 1978 Saskatchewan study indicates women in the 20 to 29 year age group are prescribed eight times as many anti-depressants as men.

Speaking at the 36th Annual Meeting of the Canadian Psychiatric Association, Dr Penfold said: "Community surveys showed 20% of women in Winnipeg had used a tranquillizer in the previous two weeks, and 15% of women in Etobicoke, Ontario, had used them in the past two days."

Other groups receiving large quantities of medication were the elderly, the chronically ill, the unemployed, the institutionalized, and those in nursing homes.

"More than half of the psychotropic medication had been first prescribed more than a year before, and almost half two years previously."

The public has been warned of serious and long-term effects from over-reliance on many commonly used drugs (**The Journal**, July).

And yet, each year more anti-depressants are prescribed.

"Today, the range of indications has expanded to include eating disorders, panic attacks, obsessive-compulsive disorder, agoraphobia, premenstrual syndrome, psychosomatic disorders, and chronic pain," said Dr Penfold.

Is the pharmaceutical industry manipulating physicians' behavior by the seductive and emotional appeal of their advertising?

Many authors think so, suggests Dr Penfold. She showed slides of pharmaceutical ads encouraging "diagnosis at a glance" and "promoting the universality of symptoms of emotional distress."

Dr Penfold: "I hear from nursing home operators of old people who are confused and disoriented on admission, but are fit to go home once their bodies are cleared of the multiple medications prescribed for them.

"Likewise, transition house workers complain many battered women are so drugged they are unable to think or plan clearly. Substance abuse program staff say that most alcoholic women are misdiagnosed and given psychotropic medication, ending up with multiple addictions."

She pointed out "many doctors seem extraordinarily naive about the big business philosophy of the pharmaceutical industry."

Whereas the physician's use of drugs may seem practical, problem oriented, and caring, in actuality, prescription of drugs may mainly be serving the pharmaceutical industry. In Canada, the industry uses one 'detail man' per 13 physicians, and, on average, each physician is visited more than 200 times per year.

Penfold examples: symptoms dubbed universal

Dr Penfold warned against the psychological effects of over-prescription of drugs.

"The person may adopt a 'sick role,' think that they have a medical problem, feel powerless to help themselves, and be dependent on a medical crutch.

"Furthermore, their family, friends, and perhaps even employer will view them as sick persons and feel no obligation to change behavior that might have contributed to the difficulties," she said.

Dr Penfold warned psychiatrists they have "a major role to play in withstanding the various pressures and inducements to prescribe medication inappropriately and in educating other physicians and the public in this respect."

Addiction awareness week focuses on public info

By Terri Etherington

TORONTO — People in Ontario and other parts of Canada will be urged to "Try Hugs, Not Drugs" during addiction awareness week (AAW), November 16 to 22.

Ontario planning groups will share the slogan, with each community running its own events and targetting specific ages or groups depending on local needs.

In Metro Toronto, the theme will involve children of alcoholics and young people.

Federal Health Minister Jake Epp is scheduled to speak at a Drug Education Coordinating Council conference here. He recently announced a federal program to increase government involvement and commitment on drug matters (see page 1).

Ontario Health Minister Murray Elston and Lieutenant Governor Lincoln Alexander are also scheduled to address the November 20 to 21 conference.

The first Canadian national conference on children of alcoholics is also set for the week, from November 16 to 18.

In Durham region, east of Metro Toronto, the theme is intergenerational events.

Suzin Jackson, of the Addiction Research Foundation Durham centre and chairperson for the Ontario AAW planning group, said community leeway is needed to tailor AAW events to the resources and problems in individual communities.

"Ideally, addiction awareness goes on all year long," Ms Jackson said.

But, "addiction awareness week is a good, non-threatening, but informative jumping-off point for other projects."

Attention-getting devices for the week include buttons, posters, T-shirts, and "hug coupons — good for one big hug and redeemable from any participating human being." Cable television programs, grand-rounds for physicians in local hospitals and treatment centres, open forums, teacher training, mock trials, and mall displays are planned.

Impact of the AAW messages will be evaluated for the first time this year in Durham. A random, street-corner survey will be used.

Other activities planned across Canada involve provincial agencies such as the Alberta Alcohol and Drug Abuse Commission, the Alcoholism and Drug Dependency Commission of New Brunswick, the Nova Scotia Commission on Drug Dependency, and the Alcohol and Drug Dependency Commission of Newfoundland and Labrador.

Addictions workers key players for industry plans

Urine testing alone does not make a drug policy: Dogoloff

By Harvey McConnell

BOSTON — Security, safety, drug use, and random urine testing in the workplace pose a dilemma for many drug abuse professionals.

While security and safety are management and not employee assistance program issues, professionals must get involved, especially with any policy involving illicit drug use.

Lee Dogoloff, executive director of the American Council for Drug Education, Washington, DC, and, James Frenck, manager of employee health advisory programs, Exxon Corporation, New York, put this message to the North American Congress on Alcohol and Drug Problems here.

Mr Dogoloff: "The questions you must ask about urine testing (**The Journal**, March) are why you are testing and what you are going to do with the results. Drug testing does not a drug policy make. On the other hand, you don't want to wait until an impaired employee, be it a school bus driver or a crane operator, has an accident."

He said it has to be pointed out repeatedly to many people that "all urine testing will tell you is that a person used the drug at some time in the past." It does not, as many seem to think, "tell you such things as how long ago the drug was used, how much was used, or how impaired the person was."

Mr Frenck said there are people "who want to get on the bandwagon" about testing and others who indulge "in a lot of denying there is a problem."

He added: "We do have a serious problem with drugs, but we have to include alcohol in that definition. The fact one drug is legal and the other is not is really a social or class definition of who is the good guy and who is the bad guy."

Urine testing and searches for drugs are thorny issues, but there are some areas, by definition, where these aren't unreasonable.

Mr Frenck: "If you are in a business where you make volatile materials, or you are running an energy source that could blow away half the city, or you are transporting the same stuff around, or if you are in the transportation business — airlines, air traffic controllers — you define fairly clearly that there is high risk.

"If there is high risk, then it is in our interest as a society to say that in these areas we may give up a bit of our freedom of choice because of the good of society and fellow workers," said Mr Frenck.

Mr Dogoloff said while those in the field should not abandon their roles in prevention as counsellors and as referral agents, the drug abuse problems of today demand more of them.

"It demands that we become outspoken advisers to management on the dimensions of the problem within the workforce and key players in the drafting and implementation of company-wide policy that is not only effective in controlling the problem, but also has integrity and demonstrates a reasonable and humane balance between company and individual rights."

Ontario backs prevention vehicles

TORONTO — French-language anti-drug videos for kids and expansion and promotion of the popular Dial-a-Fact drug information service at the Addiction Research Foundation (ARF) here have been funded by two provincial ministries.

Peter Loranger, PhD, head of ARF development and production, told **The Journal** $92,500 has been received through the Ontario Ministry of Education from the federal Secretary of State to offset costs of producing six anti-drug videos for francophone children.

The videos, already available in English, feature a puppet-scientist, Dr Cooper in English and Dr Bernard in French, and his puppet friends discussing drug topics.

The tapes are not dubbed versions of the popular English programs, but were reshot in the French language with a French director.

The ARF will be approaching French-language schools in Ontario about distribution, says Ron Hall, head of ARF information and promotion.

The Ontario Ministry of Health has approved a $149,000 expansion of Dial-a-Fact, a taped drug information service. The increased funding covers advertising of the service in Ontario, development of tapes in new areas, and a consumer survey to determine the need for further tapes in French as well as other languages.

All 51 Dial-a-Fact tapes will be available in French, and an additional four — two on women and smoking, drugs and pregnancy, and drugs and the elderly — will be produced in both French and English.

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Rock forum organizer refutes 'bias' charge

As the organizer of the public forum, Rock's Role in Drug Use: Myth or Reality (July), I would like to respond to some of the points raised in Margaret Sprenger's letter (September).

The forum was not designed as an arena for the rock industry to defend itself. As a public forum, it was designed to raise issues before the public and allow for a free exchange of ideas and opinions.

The issue, in this case, was the role of rock music in drug use. It only made sense that people from within the industry were included on the panel to shed light about the medium in which they work.

Since the Addiction Research Foundation (ARF) is a scientific organization, there was also an attempt to include scientists (Drs Ron Clavier and Jonathan Freedman), who have studied the issue, to shed light from that perspective.

As Ms Sprenger attended the forum, she would no doubt have heard the speakers mention on several occasions that drugs can harm a performer creatively. Those panelists involved in making videos or music also mentioned they do not allow drugs when work is being done. To quote rock musician and panelist Lee Aaron: "I'm here today because I'm not a drug user and don't allow it within my organization."

Surely, you cannot get a clearer indictment of drug use than that.

Ms Sprenger's letter gives the impression the panelists did not acknowledge that drugs are used in the rock industry. And yet, Ms Aaron, Ian Thomas, and Christopher Ward all mentioned rock musicians do use drugs, just as other people use drugs.

In other words, the panelists did present both sides of the issue.

Because it was a public forum, there was plenty of time allowed for those in attendance to state their views and ask questions about rock music and drug use.

One other point is worth mentioning: Ms Sprenger cites the example of a young man who says listening to music "makes you want to smoke up."

Recent surveys of drug use show that, with the exception of alcohol and tobacco, about 75% of teenagers *do not* use drugs at all. No doubt, close to 100% of them listen to rock music. How does she explain their not smoking up?

This public forum had the largest attendance of any ARF-sponsored forum to date. Important issues were raised, the public was interested, and many different opinions were expressed.

It is these qualities the ARF strives for in its public forum series, and, in my opinion, the foundation more than fulfilled its mandate in this case.

Catherine Blake
Education consultant
School for Addiction Studies
ARF
Toronto, Ontario

'Some society's assumptions are bizarre'

Rock's role in drugs

By Mark Kearney

TORONTO — The audience heard rock songs — *Smuggler's Blues, Love is a Drug,* and *I Want a New Drug.*

They also heard that rock and roll has been handed a bad rap for its part in influencing drug use and abuse among teenagers. And, that the rock music industry has cleaned up its image and is acting with more of a social conscience than ever.

Rock's role in drug use: myth or reality? was the question posed at a public forum sponsored by the Addiction Research Foundation here. "Myth" was the loud and clear answer from the panel of experts discussing the issue.

Said Christoper Ward, a 'veejay' at MuchMusic, Canada's rock video television station: "I think of drugs and rock and roll as being a fairly non-issue these days.

"Although rock and roll may be a backdrop for various people's excesses, I don't personally believe it ...rages or condones that kind of ..."

...elists agreed drug use does ... rock music industry, just ...thers, but said the link ...nd drugs was more of ...os, when illicit drug ... common.

...usicians ... and ... and ...help ...such ...ies of ...o bet-

because it is an important part of a teenager's life.

"As part of teenagers' search for independence, it becomes very important for them to find something that's their own," he said. "Fashion and music are the legacy of every generation. You can identify the generation by the music they listen to and the clothes they wear."

Mr Thomas argued that the link between rock music and drugs could be more than an attempt to find a scapegoat.

"A lot of rock and roll does support rebelliousness. Rebelliousness does support 'Let's party, let's get reckless.' And, sometimes this is where people find themselves falling victim to dope.

"So, to say rock and roll is completely clean of any connection with dope ... well, there are some connections that can be made.

"The problem is that most of the people playing rock and roll aren't saying you have to be a dope addict to be rebellious. You can be rebellious in a positive sense."

Mr Ward agreed it's rock's nature to be fun and sing songs about having a good time. That doesn't ... there's a message to use dr...

"(Rock band) Quiet ... going to write a song tell... home and lie down a... Dickinson," he sa... to tell you to ... and roll ...

"But, ... former... The ... former... and...

Quiet Riot telling you to party, not go home and read Emily Dickinson

...dn't physically manage the rigors ...forming and recording if they ...n good shape.

The Journal, July

Gilbert arecoline column quotes important studies

I read with great interest Richard Gilbert's excellent article on arecoline (July).

The studies related to its effect on memory and learning appear to be of special importance.

I would appreciate it very much if you would be kind enough to send me a list of references on these subjects or any related information.

Leslie B. Raschka, MD
Clarke Institute of Psychiatry
Toronto, Ontario

TJ 'invaluable'

Canadian views help

I find **The Journal** invaluable in keeping up to date with research and policy in the addictions field. I enjoy the international scope and the reviews of relevant literature, but also rely on **The Journal** for views of new developments in other Canadian provinces.

Like many readers, however, I miss having a publication for short articles from Canadian practitioners. What has taken the place of the Addiction Research Foundation's (ARF) pocket-sized publication *Addictions?*

Alayne Hamilton
Victoria, British Columbia

(Ed note: Addictions *was discontinued with the winter, 1977 issue. There has been no regular substitute publication, although the ARF publishes a variety of materials for practitioners. A copy of the next ARF publications catalogue will be mailed to you.)*

TJ is resource to this educator

I have regularly received **The Journal** for more than five years and as an educator have found it to be a valuable resource.

Recently, I changed schools and would like to continue to receive your publication.

Thank you for your assistance, and I wish you continued success in your endeavors.

Bronek Korczynski
Holy Cross Secondary School
Kingston, Ontario

Opinion

Learning a 1970s' lesson

By Don Smyth

OTTAWA — The current surfeit of media drug abuse horror stories has all but hidden from view the good news that where adolescents are concerned, drug use overall continues to decline (**The Journal**, December, 1985).

No one factor alone accounts for this trend. But, perhaps the most significant one is the nature of the emerging generation itself: conservative, committed, and rather competitive.

And, good news for those working in the field of prevention here: these declines have been significantly greater in eastern Ontario than elsewhere in the province. This appears to be the area where school board alcohol and other drug programs have advanced the furthest in the past five years, perhaps the result of Ontario's Addiction Research Foundation surveys which had placed the region at the top of adolescent alcohol and other drug use.

Clearly, the research of the 1970s has made measurable gains possible for school-based prevention programs once consigned to being exercises in fitfulness and failure.

The real drug challenge facing schools, parents, and our society is to make sure these outcomes are not as fragile and short-lived as a similar period in the 1970s. It wasn't just that drug programs were quickly phased out as soon as the 1960s retreated; it was our inability to come to terms with the number one drug problem: alcohol.

The parallels today with the mid-1970s are surprising. As street drug use declined, drinking among high school students increased, stimulated by the lowering of the drinking age in 1971. Yet, when drugs returned at the end of the 1970s, the gains alcohol had made in mid-decade were clearly entrenched.

The rising appeal of alcohol in the mid-1980s, particularly among young teens, is hardly surprising. The one-third increase in adult per capita consumption of alcohol in Ontario between 1970 and 1978 helps us to understand why few adolescents today believe it's possible 'to party' without alcohol; many have grown up without ever having seen adult role models 'party' with their own adult peers, even once a year, without alcohol.

Teenagers say to me, 'Sure drugs could mess you up, but what's wrong with a beer or two?' I know we have a challenge much more difficult than the challenges drug education faced so successfully in recent years.

It's not just that it's more difficult to present meaningful and realistic, short-term, health risks in drinking alcohol, the way we're able to do with the use of such drugs as cannabis or cocaine.

It took a student testifying in September before a Queen's Park legislative committee examining alcohol issues, such as the merits of raising the legal age, to put succinctly the problem which challenges us: 'You've got to be able to show that (alcohol) is not such a big deal.'

Nor is it a revolutionary overhaul that is essential at this point; just one signal to youth that the first step in responding to what Prime Minister Brian Mulroney has termed an "epidemic" will be our generation's commitment at least not to do anything to increase our own consumption of the number one drug in Canada.

Will one political leader with vision remind us, in the midst of this debate about an "epidemic," why the multi-level effort to reduce cigarette smoking was so successful with teens? The strategy was aimed simultaneously at youth *and* adults, and there's strong evidence that the declines now being reported in teenage smoking *followed* an initial decline in *adult* tobacco use.

Where alcohol issues are concerned, I'd say the odds are likelier we'll end up in Ontario with a legislative package, as in 1978, which again raises the drinking age while loosening adult access — this time beer and wine in local stores.

Wasn't it this kind of inconsistency that underlaid the 1960s?

Don Smyth is consultant to the Board of Education, Ottawa, and Council on Drug Abuse, Toronto.

1987

Heather Graham

1987

The Journal

JANUARY

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

FEBRUARY

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	19	19	20	21
22	23	24	25	26	27	28

MARCH

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
				PRIDE — International Conference, Atlanta, March 19-21		
22	23	24	25	26	27	28
29	30	31				

APRIL

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18

MAY

SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16

JUNE

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
	Institute on Prevention and Treatment of Drug Dependence, Institute on Prevention and Treatment of Alcoholism, Lausanne, May 31-June 5					
7	8	9	10	11	12	13
14	15	16	17	18	19	20

19	20	21	22	23	24	25
26	27	28	29	30		

17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

21	22	23	24	25	26	27
28	29	30				

SUN	MON	TUE	WED	THU	FRI	SAT
JULY						
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Summer School for Addiction Studies, Toronto, July 6-24

28th Institute on Addiction Studies, Hamilton, July 12-17

SUN	MON	TUE	WED	THU	FRI	SAT
AUGUST						
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

SUN	MON	TUE	WED	THU	FRI	SAT
SEPTEMBER						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

SUN	MON	TUE	WED	THU	FRI	SAT
OCTOBER						
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

SUN	MON	TUE	WED	THU	FRI	SAT
NOVEMBER						
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Addiction Awareness Week, Ontario and other provinces, November 15-21

SUN	MON	TUE	WED	THU	FRI	SAT
DECEMBER						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Freedom from Smoking at Work — Nov 5, Toronto, Ontario. Information: Lung Association, Metropolitan Toronto and York Region, 573 King St E, Ste 201, Toronto, ON M5A 1M5.

Beyond Mental Disability: Building a National Agenda for Community Support — Nov 12-15, Ottawa, Ontario. Information: Laura Thomson, director of communications, Canadian Mental Health Association, 2160 Yonge St, Toronto, ON M4S 2Z3.

The Children of Alcoholics: A Canadian Conference for the Helping Professional — Nov 16-18, Toronto, Ontario. Information: Children of Alcoholics conference, PO Box 159, Station H, Toronto, ON M4C 5H9.

Ontario Public Health Association 37th Annual Educational and Scientific Meeting — Nov 16-19, Toronto, Ontario. Information: Laura Wood, Ontario Public Health Association, Ste 210, 1335 Carling Ave, Ottawa, ON K1Z 8N8.

Event 86 — Skill Development and Training for Employee Assistance Personnel — Nov 16-20, Oakville, Ontario. Information: James Simon, Addiction Research Foundation, Georgian Bay Centre, PO Box 936, 100 Bell Farm Rd, Barrie, ON L4M 4Y6.

Addiction Awareness Week — Nov 16-22, Ontario. Information: Suzin Jackson, chairperson, Ontario AAW planning group, Addiction Research Foundation, 10th fl, 44 Bond St W, Oshawa, ON L1G 1A4.

Health Promotion Workshop —Nov 17-19, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Partnerships in Health: In a Multicultural Society — Nov 19-21, Toronto, Ontario. Information: Multicultural Health Coalition/CSM, Ste 407, 1017 Wilson Ave, Downsview ON M3K 1Z1.

Drug Education Coordinating Council 4th Annual Conference — Nov 20-21, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

Canadian Addictions Foundation Annual General Meeting — Nov 21-22, Edmonton, Alberta. Information: CAF head office, 4254-93 St, Edmonton, AB T6E 5P5.

Wellness Conference — Nov 30-Dec 3, Toronto, Ontario. Information: Lilian Toyich, Ministry of Health, office of health promotion, 8th fl, Suncor Building, 56 Wellesley St W, Toronto, ON M7A 2B7.

Fundamental Concepts Course — Jan 12-16, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Addictions Foundation Atlantic Conference 87 — April 26-30, 1987, Saint John, New Brunswick. Information: Roger A. Alain, information officer, Alcoholism and Drug Dependency Commission of New Brunswick, PO Box 6000, Fredericton, NB, E3B 5H1.

PRIDE Canada 3rd National Conference on Youth and Drugs —May 14-16, 1987, Saskatoon, Saskatchewan. Information: Eloise Opheim, president, PRIDE Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Canadian Multidisciplinary Road Safety Conference and Annual Meeting of Canadian Association of Road Safety Professionals (CARSP) — June 1-3, 1987, Calgary, Alberta. Information: Madeleine Aldridge, conference coordinator, faculty of continuing education, University of Calgary, 2500 University Dr NW, Calgary, AB T2N 1N4.

Work and Well-being 87 — June 12-14, 1987, Edmonton, Alberta. Information: Canadian Mental Health Association, #200, 12120 - 106 Ave, Edmonton, AB T5N 0Z2.

Summer School for Addiction Studies — July 6-24, Toronto, Ontario. Information: School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1

28th Annual Institute on Addiction Studies — July 12-17, 1987, Hamilton, Ontario. Information: Betty Collins, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Canadian Psychiatric Association Annual Meeting: The Human Dimensions of Psychiatry — Sept 16-18, 1987, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

United States

4th National Conference on Alcohol Policy Control Issues — Nov 11-13, Manhattan, New York. Information: Alcohol Policy IV, public information office, Division of Alcoholism and Alcohol Abuse, 194 Washington Ave, Albany, NY 12210.

American Association for Advancement of Behavior Therapy Annual Meeting — Nov 13-16, Chicago, Illinois. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018

14th Annual Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Nov 17-21, Boston, Massachusetts. Information: Kristine Niven, administrative associate, Center for the Study of Drug Development, Tufts University, 136 Harrison Ave, Boston, MA 02111

2nd Annual South Carolina Conference on Children of Alcoholics — Nov 19-21, Columbia, South Carolina. Information: Joan Burke, Lexington/Richland Alcohol and Drug Abuse Council, 2020 Washington St, Box 50597, Columbia, SC 29250.

The 2nd Annual Conference on Gambling Behavior — Nov 19-21, Philadelphia, Pennsylvania. Information: National Council on Compulsive Gambling, Inc, 444 W 56th St, Room 3207 S, New York, NY 10019.

SECAD XI: Southeastern Conference on Alcohol and Drug Abuse — Dec 3-7, Atlanta, Georgia. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, 11050 Crabapple Rd, Ste D-120, Roswell, GA 30075.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, 1987, Orlando, Florida. Information: US Journal Training, Inc. 1721 Blount Rd, Ste 1, Pompano Beach, FL 33069.

10th Annual Alcohol Symposium, Diagnosis and Treatment: New Perspectives on Old Dilemmas — March 7, 1987, Boston, Massachusetts. Information: Judy Reiner Platt, Cambridge Hospital, 1493 Cambridge St, Cambridge, MA 02139.

PRIDE 1987 International Conference on Drugs — March 19-21, 1987, Atlanta, Georgia. Information: Jean Alford, National Parents' Resource Institute for Drug Education, Inc, 100 Edgewood Dr, Ste 1216, Atlanta, GA.

American Society for Clinical Pharmacology and Therapeutics Annual Meeting — March 25-28, 1987, Orlando, Florida. Information: Elaine Galasso, executive secretary, 1718 Gallagher Rd, Norristown, Pennsylvania 19401.

American Orthopsychiatric Association Annual Meeting — March 25-29, 1987, Washington, DC. Information: Marion Langer, executive director, 19 W 44th St, Ste 1616, New York, NY 10036.

National Alcoholism Forum and Medical Scientific Conference on Alcoholism — April 22-27, 1987, Cleveland, Ohio. Information: Forum coordinator, National Council on Alcoholism, 12 W 21st St, New York, NY 10010.

American Psychiatric Association Annual Meeting: Psychiatry in Medicine: Medicine in Psychiatry — May 9-14, 1987, Chicago, Illinois. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

American Society of Hospital Pharmacists Annual Meeting — May 31-June 4, 1987, Washington, DC; Clinical Meeting, Dec 6-10, 1987, Atlanta, Georgia. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

3rd Annual National Rural Institute on Alcohol and Drug Abuse — June 7-11, 1987, Eau Claire, Wisconsin. Information: National Rural Institute on Alcohol and Drug Abuse, Arts and Sciences Outreach, University of Wisconsin, Eau Claire, WI 54702-4004.

National Clergy Council on Alcoholism and Related Drug Problems Annual Meeting — June 15-19, 1987, St Augustine, Florida. Information: Rev. John O'Neill, executive director, 1200 Varnum St NE, Washington, DC 20017

Committee on Problems of Drug Dependence and the Research Society on Alcoholism, Joint Meeting — June 15-19, 1987, Philadelphia, Pennsylvania. Information: Martin W. Adler, Temple University, dept of pharmacology, 3420 N Broad St, Philadelphia, PA 19140.

American Medical Association Annual Meeting —June 21-25, 1987, Chicago, Illinois; Dec 6-9, 1987, Atlanta, Georgia. Information: James H. Sammons, executive vice-president, 535 N Dearborn St, Chicago, IL 60610.

International Doctors in Alcoholics Anonymous Annual Meeting — July 30-Aug 7, 1987, Lexington, Kentucky. Information: L. K. Reed, secretary-treasurer, 1950 Volney Rd, Youngstown, Ohio.

American Hospital Association Annual Meeting — Aug 3-5, 1987, Philadelphia, Pennsylvania. Information: John A. McMahon, president, 840 N Lake Shore Dr, Chicago, Illinois.

United States National Woman's Christian Temperance Union Annual Meeting — Sept 3-7, 1987, Camp Hill, Pennsylvania. Information: Mrs K. Edgar, president, 1730 Chicago Ave, Evanston, Illinois.

American Association for Automotive Medicine Annual Meeting — Sept 27-29, 1987, New Orleans, Louisiana. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Oct 3-7, 1987, Chicago, Illinois. Information: Thomas J. Delaney, executive director, ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

American Public Health Association Annual Meeting — Oct 18-22, 1987, New Orleans, Louisiana. Information: William McBeath, 1015 15th St NW, Washington, DC 20005.

Abroad

6th Annual Conference of the Australian Medical Society on Alcohol and Drug Related Problems — Dec 9-12, Perth, Western Australia. Information: Ms Kari McLaughlin, Western Australian Alcohol and Drug Authority, Construction House, Level 2, 35 Havelock St, West Perth, 6005 Western Australia.

International Federation of Non-Governmental Organizations for the Prevention of Drug and Substance Abuse 8th Annual Conference —Dec 13-19, Sydney, Australia. Information: Chairman, program committee, PO Box 477, Canberra City ACT 2601, Australia.

Symposium on the Prevention of Alcohol Misuse Among Children and Young People — Feb 25-26, 1987, London, England. Information: Institute of Alcohol Studies, Alliance House, 12 Claxton St, London, SW1H 0QS

The International Congress for Alcoholism and Drug Abuse Counselors — March 13-21, 1987, London, England. Information: Tom Claunch, CAC, chairperson, PO Box 210638, Montgomery, Alabama 36121

7th International Conference on Alcohol Problems — April 5-10, 1987, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

16th International Institute on the Prevention and Treatment of Drug Dependence and the 33rd International Institute on the Prevention and Treatment of Alcoholism — May 31-June 5, 1987, Lausanne, Switzerland. Information: International Council on Alcohol and Addictions, Case postale 189, 1001 Lausanne, Switzerland.

First project focuses on methadone treatment

Australia sets up national drug-research centre

By Thomas Land

SYDNEY — Australia has set up a national addiction research institution at the University of New South Wales, Kensington.

The move reflects the government's growing anxiety about the medical and social effects of drug smuggling.

Earlier this year, a special educational, clinical, and research unit was established at the Royal Darwin Hospital to deal with addiction problems.

And, the government has sent 20 federal police liaison officers overseas to provide intelligence reports on illicit drug trends and to update records on the movement of prominent criminals.

Australia's new National Drug and Alcohol Research Centre is funded by an annual $640,000 (Cdn $572,800) government grant channelled through the New South Wales Drug and Alcohol Authority.

Its interim director is Ian Webster, MD, professor of community medicine at the University of New South Wales. He says the institution's essential purpose is "research and development of effective treatment and rehabilitation programs."

Sydney: fear of cocaine influx from North America inspires national action on drugs

The effects of both legal and illegal drugs will be studied, with the first project focusing on methadone.

"Current policies and practice in methadone treatment raise critical social and ethical issues," explains Dr Webster, "both for the national drug offensive and for the future directions of drug rehabilitation programs."

The new national centre will seek to foster a national network of research activities.

Emeritus Professor Syd Lovibond comments: "The major research theme will be dependence: how it starts, what keeps it going, how it stops. If we can solve these questions, we may learn how best to intervene in drug dependence."

The steering committee of the institution has embarked on a program stretching into long-term follow-up studies.

An earlier initiative of Australia's national campaign against drug abuse led to the establishment of the pioneering Alcohol and Drugs Early Intervention Unit at the Royal Darwin Hospital. It is to develop, evaluate, and implement methods for the identification, assessment, and management of alcohol and other drug problems and to increase the awareness and skills of medical staff in managing drug-dependent patients.

Such projects are vigorously encouraged by the government which fears a flood of drug abuse in Australia in the wake of global trends. Specialists warn the present oversupply of cocaine in North America may spill into Australia and may lead to domestic cultivation.

Drug authority would centralize efforts in Israel

TEL AVIV — The establishment of a drug authority to coordinate all government activities and to work closely with private and public bodies in the drug field has been proposed here by Israeli Minister of Labor and Social Welfare Moshe Katzau.

He says the present system, in which his ministry, the Ministry of Police, and the Ministry of Health deal with the problem, has led to considerable duplication and inefficiency.

He wants the authority to be an integral part of labor and social welfare since, he says, social welfare rehabilitation aspects are of greatest importance.

Law chiefs review proposed UN drug treaty

VIENNA — The first world meeting of national drug-law enforcement chiefs here discussed the proposed new United Nations convention on illicit traffic in narcotic and psychotropic drugs.

Chiefs of national drug enforcement agencies in the Far East region have been meeting annually for 12 years. This was the first inter-regional meeting.

The draft convention is the third major international treaty against narcotics (**The Journal**, March).

Meeting chairman Neville Nagler of the United Kingdom said the fact the international community is still prepared to devote time, energy, and money to the fight against drug misuse and illicit trafficking is proof despair is not, and could not be, on the agenda.

He said it has now become almost a truism that international cooperation in the fight is no longer an option but a necessity.

Peter Jankowitsch, Austrian foreign minister, said the inter-regional meeting "represents a new dimension of international organization and cooperation."

William B. Buffum, UN under secretary-general for political and General Assembly affairs and coordinator of all UN drug-abuse related programs, said the draft convention marks "an extremely encouraging and important development in strengthening international law."

Public health budget eaten up

Templars cite costs of alcohol

ZURICH — Policy makers, governments, and voluntary organizations have been reminded here of the need to recognize the real role alcohol plays in society.

Nearly 2,000 delegates to the world congresses of the International Organization of Good Templars and the International Good Templar Youth Federation — from 40 countries — pointed out research shows the serious impact alcohol has on development and the pressure alcohol-related problems exert on the "economic and social fabric" of all nations, even the most affluent.

"No nation can afford a cost absorbing one-third of the public health budget and reaching a direct cost equal to more than 5% of the gross national product of industrialized countries," a Templar resolution states.

HOWELL

The shibboleth epidemic

"This," snorted my friend Professor Bottomsworthy, poking his finger at a pile of newspaper clippings on his desk, "is a very dangerous trend."

I leafed through the clippings. They seemed innocuous enough to me: there were clippings of Canadian Prime Minister Brian Mulroney's recent announcement of a new federal initiative to combat what he referred to as a drug "epidemic," and clippings of the various news stories and editorials that had followed in the wake of his announcement.

I didn't see any dangerous trend; in fact, the various statistics bandied about in the wake of the Mulroney announcement suggested that the crack problem was virtually non-existent in Canada and drug use among teenagers appeared to be on the decrease.

"All this looks encouraging, not discouraging," I said.

"As usual, you've missed the point entirely," the professor groaned. "A so-called drug epidemic is not the dangerous trend to which I refer; it is the reaction to Mr Mulroney's statement about the epidemic that I see as the dangerous trend. A surfeit of scepticism, a riot of rationality, an orgy of objectivity, call it what you will, but this is very definitely a dangerous trend.

"Do you know what it means for the future? Consider this: Mr Mulroney gave the drug "epidemic" only cursory mention in a speech that ran to 3,500 words.

"But, this was enough to stir up a virtual hornet's nest of criticism: the drug experts attacked him, the opposition politicians attacked him, the newspapers attacked him. The experts fired off letters to the editor pointing out that if the word epidemic had anything to do with death and disease, then the drug Mr Mulroney should be concerned with was tobacco; the politicians attacked him for making policy on the fly and for rampant 'me-too-ism' given that Nancy and Ron (Reagan) were into drug epidemics in a big way; and, the newspapers attacked his credibility (did he say 'uh-huh' to the question of urine testing or did he say 'uh-uh?'). In general, everyone gave him a very rough time.

"Now, consider all this happened because of one minor reference to the drug epidemic, normally one of the safest shibboleths in the politician's lexicon. A politician does not expect to get attacked for being in favor of Free Enterprise, Family, and Motherhood, nor does he expect to get attacked for being opposed to Communism, Organized Crime, and the Drug Epidemic. Certain things are sacred."

"I'm beginning to see your point," I said. "You're worried about where this 'riot of rationality' might lead; you're worried some other politician might be savaged in the manner Mr Mulroney was, just for innocently slipping what is normally considered a 'safe shibboleth' into a speech."

"Exactly. Just imagine, for instance, that in the course of a speech a politician pays ritual obeisance to Free Enterprise. And the next thing he knows, everyone — the politicians, the editorial writers, the columnists, the letters-to-the-editor writers — are on his case.

"How free is it anyway? How come if it's so free, only a small minority of citizens own most of the enterprises? Why is this good for the people who don't own enterprises and never will? And so on and so forth.

"And if you think the implications for Canada are bad, think about what would happen if this orgy of objectivity were to spread to the United States. Good heavens, a politician couldn't even quote shibboleths stamped right onto Legal Tender without a cascade of criticism. Why do we trust in God? And in which God do we trust anyway? And if we trusted in a Japanese god, would that mean we could make cars as well as they do? And so on, and so forth. I tell you, we are looking Chaos in the eye."

The professor seemed genuinely distraught.

"Calm yourself," I said, placing the clippings back on his desk. "I suspect that, as usual, your theories have outrun your evidence. I suspect what we are seeing here is a situation unique to the drug field. It is a field where sophistry in various forms — the latest being that marijuana use can lead to AIDS — alternates with brief episodes of Socratic scepticism — such as the period of the LeDain inquiry.

"It is a field where traditionally, the *cognoscenti*, that is to say the professional experts, actually encourage sophistries of various kinds because they honestly believe the public is better served by simple lies than complicated truths. Given this, it is natural that, from time to time, scepticism erupts with a vengeance, injuring innocents such as Mr Mulroney. . . ."

"A guy who set out to mouth a few platitudes, and ended up eating crow," interrupted the professor.

"Right. As I said, this is a situation unique to the drug field," I continued. "So, I don't see that this unprecedented eruption of scepticism and rationality will necessarily translate into a dangerous trend that will affect other areas of political discourse as you suggest."

"You may be right," Professor Bottomsworthy said, with a hint of a twinkle in his eye. "As a matter of fact, you definitely are. Assuming, of course, that the drug field is unique, and that experts in other fields — economics, foreign relations, disarmament, nuclear energy, etc — do not encourage the propagation of simple lies rather than complex truths. Why, if that is the case, we have nothing at all to worry about. Nothing at all."

By Wayne Howell

COMMENT

GILBERT

Vitamins and popular drugs: II

Last month, I commented briefly on Linus Pauling's recent book, *How to Live Longer and Feel Better*, noting that the book is thin in its treatment of interactions between vitamins and popular drugs. The balance of that column added notes about interactions involving ascorbic acid (vitamin C). Here, I shall note interactions between popular drugs and other human vitamins.

A word about nomenclature: some vitamins have many forms with similar or identical functions. For example, both retinol (vitamin A_1) and dehydroretinol (vitamin A_2) have vitamin A activity. However, the compounds in the vitamin B group have different functions and properties. Once, there were thought to be 17 such vitamins, named B_1 to B_{17}. Now only the numbers 1, 2, 3, 6, and 12 are used. The remaining compounds were found to be duplicates (eg, B_7, which turned out to be the same as B_3), or not essential for good health. Newly discovered vitamins of this type are now given simplified chemical names (eg, folic acid — see below). The trend is to use such names for vitamins B_1, B_2, B_3, B_6, and B_{12} (eg, niacin — see below).

Vitamin A (retinol, or its precursor carotene): This fat-soluble vitamin is sometimes called the anti-ophthalmic factor because of its importance for vision. It is also necessary for the maintenance of epithelial tissues in a normal state, including tract linings, cornea, and skin. Sources are yellow vegetables and fruit. The recommended daily allowance for non-pregnant adults (RDA) is 5,000 International Units (IU). Dr Pauling recommends 20,000 to 40,000 IU.

Because many cancers concern epithelial cells, links have been suspected between cancer incidence and vitamin A intake. Usually, the expected negative association has been found — low vitamin A intake associated with cancers of the mouth and respiratory tract — but the results are mixed. Also, a recent study suggests a positive association between dietary vitamin A and incidences of Hodgkin's disease and leukemia.

Retinol does not appear to enhance or inhibit the mutagenicity of cigarette smoke in bacterial tests. Its cancer-preventing ability, if any, may depend on the maintenance of epithelial tissue in good shape rather than on specific chemical inhibition.

From what is known about vitamin A, modest intake above the RDA probably prevents deterioration and cancer of the mouth and respiratory tract caused by smoking or excessive alcohol use, or both. The supplementation may be especially useful in alcohol abuse, for alcohol appears to slow the conversion by the liver of dietary carotene to active vitamin A. Large-scale trials of the preventive effects of retinol supplements are under way in Seattle, Washington.

High levels of vitamin A administered to mice have been found to produce dwarfism. This effect can be partially countered by administration of caffeine.

Vitamin B_1 (thiamine): Beriberi is the characteristic sign of deficiency of this vitamin, which is necessary for the maintenance of the health of nerve tissue, intestinal and cardiovascular function, appetite, and growth. The main dietary source is unrefined cereals. The RDA is 1.5 milligrams. Dr Pauling recommends 50 to 100 mg.

Alcohol may cause lower than desirable vitamin B_1 levels in two ways. It may be substituted for more nutritious foods in the diet and cause deficiencies of many vitamins, but particularly of vitamin B_1 because it is rapidly metabolized. Alcohol may also reduce absorption of thiamine by the gut. Thus, intake of higher than the RDA may be advised in cases of alcohol abuse.

Thiamine treatment, as much as 300 mg per day, is used in cases of Wernicke-Korsakoff Syndrome, a condition associated with chronic heavy alcohol use and characterized by delusion and memory deficits. Improvement is most noticed where there has been explicit thiamine deficiency.

The question of whether to add vitamins to alcoholic beverages raises concerns rather like those about giving contraceptives to teenagers

Beriberi is chiefly a disease of the peripheral nerves, which suggests that neuropathy in alcoholics may be related to deficiencies in vitamin B_1. A recent West German study found no such relation. The muscular atrophy often found in alcoholics might also be related to thiamine deficiency, if it were consequent on neuropathy. Current research suggests that thiamine deficiency is not a factor.

Vitamin B_2 (riboflavin): This vitamin is sometimes known as lactoflavin or hepatoflavin because milk and liver are the main natural sources. Deficiency is associated with skin diseases, including pellegra, and with lip and mouth lesions. The RDA for vitamin B_2 is 1.7 mg. Dr Pauling recommends 50 to 100 mg. The high riboflavin levels of vitamin supplements give a fluorescent yellow-green color to the urine of users.

Little research has been done on vitamin B_2 status in relation to popular drug use. A recent study from Cornell University indicates that riboflavin deficiency can be induced in guinea pigs by feeding them alcohol-containing diets, which may point to need for supplemental use in alcohol abuse.

Vitamin B_3 (niacinamide or nicotinamine — also known historically as vitamin B_7): This vitamin is often taken as niacin (also known as nicotinic acid or vitamin PP — pellegra prevention factor). It is synthesized by bacteria in the gut, but not usually in sufficient quantities for the host's good health. Dietary sources are yeast and lean meat. The RDA is 18 mg. Dr Pauling recommends 300 to 600 mg. Such quantities produce unpleasant symptoms when taken for the first time, including flushing, itching, vasodilation, increased cerebral blood flow, and decreased blood pressure. These effects are exploited in certain therapeutic uses of niacin — in angina and in phlebitis. (Niacin also raises high-density lipoprotein levels, known to be inversely associated with incidence of coronary heart disease.) Large niacin doses have also been used to treat schizophrenia.

Huge doses of niacin (9,000 mg per day) have been given with other vitamins to control alcoholism, with reported success. This work dates back several decades. Recent confirmation does not appear to be available.

Roasted coffee contains niacin — about 7 mg per cup — and has been used therapeutically to combat pellegra. Conversely, niacin supplementation has been used to treat excessive coffee use. Niacin has been found to antagonize some of caffeine's toxic and other effects.

Vitamin B_6 (pyridoxine): This vitamin is believed to act as a coenzyme for more than 100 different enzymes. It plays a key role in the mobilization of oxygen for muscles and is thus considered of possible value in the treatment of muscular dystrophies. The RDA is 2.2 mg. Dr Pauling recommends 50 to 100 mg. Temporary peripheral blindness has been noted when more than 2,000 mg has been administered.

Two possible causes have been suggested for the frequent deficiency of vitamin B_6 in alcoholics. Alcohol may inhibit the absorption of pyridoxine from the intestine. Acetaldehyde (the main intermediate metabolite of alcohol) may cause pyridoxine to break down prematurely in the blood. Reduced levels of this vitamin have also been found in smokers — possibly the result of their higher alcohol use. The reduced levels of pyridoxine found in alcoholics are not associated with diminished conduction velocity of sensory nerves or with muscular atrophy.

Folic Acid (folacin): This member of the B complex of vitamins has anemia as its characteristic deficiency symptom. The RDA is 400 micrograms (mcg). Dr Pauling recommends 400 to 800 mcg.

Folic acid and related compounds are widely involved in the formation of new body cells — red blood cells being just one example. Folate-dependent, fragile sites have been recognized on chromosomes, suggesting that folate deficiency may lead to tumors and cancer.

Alcohol use has been found to produce lowered serum and tissue concentrations of folates. Folic acid supplementation has been used in the treatment of alcohol withdrawal.

Vitamin D (calciferol): Deficiency of vitamin D causes rickets and other bone diseases. Deficiency has also been associated with an increased risk of colorectal cancer. Vitamin D is fat soluble and stored in the liver. Large doses — perhaps the result of eating certain animal livers — produce a range of disabling effects including decreased renal function and joint pains. The RDA is 400 IU. Dr Pauling recommends 800 IU.

Osteoporosis (thinning of bone texture) in post-menopausal women has been found to be associated with low vitamin D levels. Smoking and, possibly, heavy caffeine use contribute to osteoporosis. The heightened liver activity characteristic of smoking may cause excessive metabolism of vitamin D and consequent deficiency.

Alcohol may impair metabolism of this vitamin, causing accumulation of it. Bone disease in alcohol abusers has been found to be unrelated to vitamin D status.

Vitamin E (tocopherol): The status of this substance as a human vitamin is still in doubt, even though the United States Food and Nutrition Board decided in 1968 that it is essential. Dr Pauling regards vitamin E as second only to vitamin C in importance. He writes:

"*Vitamin E, the fat-soluble antioxidant vitamin, and vitamin C, the water-soluble antioxidant vitamin, collaborate in protecting the blood vessels and other tissues against damage by oxidation. They slow down the process of deterioration of the body with passage of time and help prevent cardiovascular disease. They have value as an adjunct to appropriate conventional therapy in the treatment of cardiovascular disease and other diseases.*"

The RDA is 10 IU. Dr Pauling recommends 800 IU.

Little research has been conducted on interactions between vitamin E and popular drugs. Some studies suggest that dietary supplements of this vitamin may provide protection against tissue damage caused by smoking.

Other vitamins: There appears to be no recently reported research on interactions between popular drugs and **vitamin B_{12}** (cobalamin or cyanocobalamin — active in protein synthesis, production of red blood cells, and neural functioning), **biotin** (once named vitamin H, but now considered to be part of the B complex), **pantothenic acid** (a member of the B complex that is part of coenzyme A, a most important coenzyme that occurs widely in biological systems and is a co-factor for many enzymes — not to be confused with vitamin A), and **vitamin K** (essential for blood coagulation; normally produced in sufficient quantities by intestinal bacteria).

Antidote to abuse

This accumulation of sparse evidence suggests that alcohol or tobacco use (or both) generally depletes the body of vitamins and that dietary supplementation is advisable as an antidote to the effects of abuse. Dietary supplementation may also assist the body in other ways in its handling of abuse of these popular drugs.

Heavy use of caffeine does not appear to interact with vitamin levels and functions to the same degree, although this conclusion may reflect no more than paucity of evidence. Considering, for example, the potential involvement of both folic acid and caffeine in nucleic acid biosynthesis, evidence of their interaction should not be surprising.

The question of whether to add vitamins to alcoholic beverages raises concerns rather like those about giving contraceptives to teenagers. If booze is made safer, goes the argument, people will drink more of it.

Some doctors have explicitly recommended use of vitamin supplements by drinkers. Robert Linn, for example, in his 1979 book, *You Can Drink and Stay Healthy*, advised drinkers to take the following additional amounts of vitamins each day: B_1 - 50 mg, B_2 - 30 mg, B_3 - 50 mg, B_6 - 100 mg, and calcium pantothenate - 30 mg. Except for B_6, these amounts are lower than those recommended by Dr Pauling for drinkers and non-drinkers.

Drinkers are unlikely to be aware of the interactions between vitamins and popular drugs and the possible need for supplementation. Large health benefits might result from adding vitamins to alcoholic beverages and mixes. More intense consideration should be given to this matter by policy makers concerned about the effects of alcohol. Smokers will have to rely on information rather than adulteration, because most vitamins are destroyed at the temperature of burning tobacco.

By Richard Gilbert

STATS·FACTS:WOMEN

Manuella Adrian, head, statistical research program, Addiction Research Foundation, based Stats•Facts on: Statistics on Alcohol and Drug Use in Canada and Other Countries, Volumes 1 and 2 *(based on data available by September, 1984).*

Alcohol

How many Canadian women drink?

A 1984 Ontario survey indicates 82% of women or 7.8 million aged 18 years and older have used alcohol at least once in the previous year. Thirty-seven percent of Ontario women drink five drinks or more at a single sitting, and 29% report becoming "high" or "tight." However, 18% of women are abstainers.

Based on Canadian Gallup surveys, women were more in favor of raising the legal drinking age (1983), increasing the price of alcoholic beverages (1981), and increasing government advertising on the dangers of drink (1981), than men.

How many contravene alcohol laws?

Women accounted for 35,750 or 8.2% of all charges laid in Canada for alcohol-related offences, including Liquor Acts offences, failing or refusing a breath sample, and driving while impaired (1982). According to 1979 Ontario court data, 6.4% of all convictions for alcohol-related driving offences (driving while impaired, having a blood alcohol level in excess of 0.08%, or refusing a breath sample) were for women.

Based on Canadian Gallup surveys, women were more in favor of random breath tests (1981), tougher sentences for drinking and driving (1981), and jailing drivers who had had more than one alcoholic drink (1983), than men.

How many have alcohol-related health problems?

In 1981, there were an estimated 189,000 female alcoholics, 32% of all alcoholics in Canada. In 1980/81, in general hospitals in Canada, women accounted for 11,484 or 26% of all cases treated for alcohol-related problems: alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, toxic effects of alcohol, and chronic liver disease and cirrhosis.

In 1981/82, in mental hospitals in Canada, women accounted for 762 or 18% of all cases treated for alcohol-related problems: alcohol dependence syndrome and alcoholic psychoses.

A 1982/83 survey of all types of alcohol treatment services in Ontario indicated women accounted for 10,189 or 16.5% of all cases treated for alcohol-related problems. Treatment was provided in detoxification centres and in hospital- and community-based residential and non-residential facilities.

How many receive a disability pension because of alcohol-related problems?

Women accounted for 190 or 11% of all disability pensions received for alcohol-related conditions (based on pensions issued February, 1980).

How many die of alcohol disorders?

In 1982, in Canada, women accounted for 931 or 30% of all deaths from alcohol-related diseases: chronic liver disease and cirrhosis, alcohol dependence syndrome, alcoholic psychoses, non-dependent abuse of alcohol, and toxic effects of alcohol.

Tobacco

How many Canadian women smoke?

A 1982 survey shows 29% of women aged 15 years and older are regular cigarette smokers on a daily basis, another 3.5% are occasional cigarette smokers, and 11% are former smokers.

How many die of smoking-related health problems?

In 1982, there were 17,361 deaths due to smoking-related conditions. This includes, as suggested by comprehensive standards of the (then) United States Department of Health, Education and Welfare, all deaths due to chronic bronchitis, asthma, and emphysema, and 30% of deaths due to neoplasms and diseases of the circulatory system such as stroke, hypertension, and heart disease.

Other Drugs

What is the most used drug among Canadian women?

Pain relievers.

The Canada Health Survey states 19.4% of women aged 15 years and older (1.7 million) used pain relievers in the two days prior to the survey (1978/79).

How many women in Canada use sleeping pills?

An estimated 940,000 Canadian women aged 18 years and older, or 9.9%, used sleeping pills at least once in the previous year (1984 Ontario survey).

How many use tranquillizers?

An estimated 1.2 million Canadian women 18 years and older, or 12.3%, used tranquillizers at least once in the previous year (1984 Ontario survey).

How many use stimulants?

An estimated 250,000 or 2.6% of Canadian women aged 18 years and older used stimulants at least once in the previous year (1984 Ontario survey).

How many use cannabis?

An estimated 668,000 Canadian women (7.1%) aged 18 years and older used marijuana at least once in the previous 12-month period (1984 Ontario survey).

How many use cocaine?

An estimated 180,000 women or 1.9% aged 18 years and older used cocaine at least once in the previous 12 months (based on a 1984 Ontario survey).

How many use narcotic drugs?

There were 3,299 women illicit-narcotic drug users in Canada, or 22% of all users coming to the attention of the Bureau of Dangerous Drugs (1982).

How many were involved in drug crimes?

In 1982, there were 4,524 charges against Canadian women, or 10.5% of all drug-related charges for criminal offences under the Narcotic Control Act and the Food and Drugs Act.

How many were sent to jail?

In 1979, women accounted for 70 admissions to jail for drug-related offences. This includes admissions to federal penitentiaries and provincial and territorial correctional facilities. Forty-five women were admitted to Canadian penitentiaries (which hold prisoners sentenced for two years or more); they accounted for 35% of all female admissions to the penitentiaries, but only 9% of all drug admissions.

In addition, there were 25 drug-related admissions to provincial/territorial correctional institutions (which hold prisoners for less than two years). They accounted for 3% of all female admissions and of all drug admissions (based on data from the Maritime provinces and Manitoba).

How many have drug-related health problems?

In 1980/81, in general hospitals in Canada, women accounted for 10,891 or 60% of all cases treated for drug-related problems: drug psychoses, drug dependence, non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotropics.

In 1981/82, in mental hospitals in Canada, women accounted for 312 or 34% of all cases treated for drug-related problems: drug psychoses, drug dependence, and non-dependent abuse of drugs.

How many receive a disability pension for drug-related problems?

Two women received a disability pension for drug-related conditions (based on pensions issued during February, 1980).

How many die of drug disorders?

In 1982, there were 271 women who died from drug-related diseases, accounting for 52% of all drug deaths. These included deaths from non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotropics.

(Stats•Facts: Men, page 10)

STATS·FACTS:MEN

Alcohol

How many Canadian men drink?

A 1984 Ontario survey indicates an estimated 7.8 million or 86% of men aged 18 years and older have used alcohol at least once in the previous year. Sixty-one per cent of Ontario men drink five drinks or more at a single sitting, and 52% report becoming "high" or "tight." However, 14% of men are abstainers.

Based on Canadian Gallup surveys, men were less in favor of raising the legal drinking age (1983), increasing the price of alcoholic beverages (1981), and increasing government advertising on the dangers of drink (1981), than women.

How many contravene alcohol laws?

Men accounted for 397,548 or 92% of all charges laid for alcohol-related offences, including Liquor Acts offences, failing or refusing a breath sample, and driving while impaired (1982). Ontario court data (1979) shows 94% of all convictions for alcohol-related driving offences (driving while impaired, having a blood alcohol level in excess of 0.08%, or refusing a breath sample) were for men.

Based on Canadian Gallup surveys, men were less in favor of random breath tests (1981), tougher sentences for drinking and driving (1981), and jailing drivers who had had more than one alcoholic drink (1983), than women.

How many have alcohol-related health problems?

In 1981, there were an estimated 397,600 male alcoholics, 68% of all alcoholics in Canada. In 1980/1981, in general hospitals, men accounted for 32,537 or 74% of all cases treated for alcohol-related problems: alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, toxic effects of alcohol, and chronic liver disease and cirrhosis.

In 1981/82, in Canadian mental hospitals, men accounted for 3,461 or 82% of all cases treated for alcohol-related problems: alcohol dependence syndrome and alcoholic psychoses.

A 1982/83 survey of all types of alcohol treatment services in Ontario indicated men accounted for 51,639 or 83.5% of all cases treated for alcohol-related problems. Treatment was provided in detoxification centres and in hospital- and community-based residential and non-residential facilities.

How many receive a disability pension because of alcohol-related problems?

Men accounted for 1,544 or 89% of all disability pensions received for alcohol-related conditions (based on pensions issued February, 1980).

How many die of alcohol-related disorders?

In 1982, men accounted for 2,132 or 70% of all deaths from alcohol-related diseases: chronic liver disease and cirrhosis, alcohol dependence syndrome, alcoholic psychoses, non-dependent abuse of alcohol, and toxic effects of alcohol.

Tobacco

How many Canadian men smoke?

A 1981 Canadian survey shows 37% of men aged 15 years and older are regular cigarette smokers on a daily basis. Another 3.4% are occasional cigarette smokers, and 20% are former smokers.

How many die of smoking-related health problems?

In 1982, there were 21,751 deaths due to smoking-related conditions. This includes, as suggested by comprehensive standards of the (then) United States Department of Health, Education and Welfare, all deaths due to chronic bronchitis, asthma, and emphysema, and 30% of deaths due to neo-

plasms and diseases of the circulatory system such as stroke, hypertension, and heart disease.

Other Drugs

What is the most-used psychoactive drug among Canadian men?

Cannabis.

An estimated 1.4 million or 15.6% of men aged 18 years and older used marijuana at least once in the previous 12-month period (based on a 1984 Ontario survey).

How many use cocaine?

An estimated 430,000 or 4.8% of men aged 18 years and older used cocaine at least once in the previous year (based on a 1984 Ontario survey).

How many use tranquillizers?

An estimated 500,000 or 6.1% of men aged 18 years and older used tranquillizers in the previous year (based on a 1984 Ontario survey).

How many use sleeping pills?

An estimated 420,000 or 4.6% of men 18 years and older used sleeping pills at least once in the previous 12 months (based on a 1984 Ontario survey).

How many use stimulants?

An estimated 220,000 or 2.4% of men used stimulants at least once in the previous 12 months (based on a 1984 Ontario survey).

How many use narcotic drugs?

There were 11,996 men using illicit narcotics in Canada, or 78% of all users coming to the attention of the Bureau of Dangerous Drugs (1982).

How many were involved in drug crimes?

In 1982, there were 38,498 charges against men in Canada, or 89.5% of all drug-related charges for criminal offences under the Narcotic Control Act and the Food and Drugs Act.

How many were sent to Canadian jails for drug offences?

In 1979, men accounted for 1,232 admissions to jail for drug-related offences. There were 437 men admitted for drug offences to Canadian penitentiaries (which hold prisoners sentenced to two years or more). Men account for 91% of all drug-related admissions to these institutions.

Another 795 men were admitted to provincial/territorial correctional institutions (which hold prisoners sentenced for less than two years). Men represent 97% of all drug-related admissions to these institutions (based on data from the Maritime provinces and Manitoba).

How many have drug-related health problems?

In 1980/81, in general hospitals in Canada, men accounted for 7,257 or 40% of all cases treated for drug-related problems: drug psychoses, drug dependence, non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotropics.

In 1981/82, in mental hospitals in Canada, men accounted for 619 or 66.5% of all cases treated for drug-related problems: drug psychoses, drug dependence, and non-dependent abuse of drugs.

How many receive a disability pension for drug-related problems?

There were seven men who received a disability pension for drug-related conditions (based on pensions issued during February, 1980).

How man men die of drug-related disorders?

In 1982, there were 247 men who died from drug-related diseases, accounting for 48% of all drug deaths. These included deaths from non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotropics.

These data are based on administrative reporting systems, or on surveys of the general population. Estimates based on surveys are approximate figures only. The real figures may be slightly smaller or larger.

Figures from administrative records depend on reported data; unreported occurrences cannot be included. For example, treatment given in a non-hospital setting is necessarily excluded from hospital treatment data.

Statistics on other target groups will be addressed from time to time in forthcoming editions of The Journal. Stats•Facts already published in The Journal include: Youth (June, 1985), Adults (November, 1985), and Older Canadians (May).

Readers requiring statistics are invited to write to The Journal, 33 Russell St, Toronto, Canada M5S 2S1.

DEPARTMENTS

New Books

by MARGY CHAN

Physician's Handbook for Medical Management of Alcohol- and Drug-related Problems

. . . compiled and edited by Paul Devenyi and Sarah J. Saunders

Jointly published by the Ontario Medical Association and the Addiction Research Foundation (ARF), this pocket-sized handbook provides a quick reference source for interns, residents, family physicians, and emergency workers on recognition and early medical management of alcohol- and other drug-related problems. The appendix lists useful addresses and telephone numbers in Ontario: ARF community services division offices, alcohol/drug assessment and referral centres, and detoxification centres.

Addiction Research Foundation, Toronto, 1986. 75 p. $5. ISBN 0-88868-115-1.

Coca and Cocaine: Effects on People and Policy in Latin America

. . . edited by Deborah Pacini and Christine Franquemont

This is a collection of papers from the conference, the coca leaf and its derivatives: biology, society and policy, April, 1985. The purpose is to present the current state of knowledge about the coca leaf and its chemical derivatives and to examine what is going on in the coca-producing regions of Latin America.

Written by a multidisciplinary group of specialists on coca, the book covers: coca chewing and the botanical origins of coca in South America, coca and cultural identity in Andean communities, notes on pre-Colombian cultivation of coca leaf, coca production in the Bolivian Yungas in the colonial and early national periods, the international narcotics control system, the foreign politics of cocaine, the Colombian Connection, some recent effects of foreign cocaine markets on Bolivian rural society and economy, and the political and economic implications for tribal Amazonian Indians.

These proceedings trace the cocaine issue from its roots to its ramifications: the coca leaf is considered as a plant, as a commodity, as a source of power, and as a symbol.

Cultural Survival, Inc, Cambridge, Massachusetts. 164 p. $8. ISBN 0-939521-24-5.

Other books

Turnabout: Help for a New Life — Jean Kirkpatrick, 1986. This is a personal account of the author's experience as a recovered alcoholic. She is now executive director of Women for Sobriety, Inc. Madrone Publishers, Seattle. 183 p. $8.95. ISBN 0-88089-017-7.

Healthy Ways — Sharon Gibb, 1985. A community-based health education program designed to help grade one to six students explore life skills issues is detailed. The series contains six action books and two teacher resource guides. Doubleday Canada, Toronto.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Drugs and You

Number: 757.
Subject heading: Drugs and youth.
Details: Five, 10-min filmstrips with audiotapes.
Synopsis: Many drugs are used by young people, causing physical, social, and legal problems. The effects of marijuana and drugs such as heroin and cocaine are illustrated by case studies of users. One of the best ways to avoid drug use is to have goals and work toward them. It also helps to have confidence in one's abilities and to realize drug use causes, not solves, problems.
General evaluation: Very poor to poor (1.9). Although there are some positive messages, the filmstrips' use of stereotypes and the poor visuals detract.
Recommended use: None.

Uppers and Downers

Number: 754.
Subject heading: Drug use: pharmacology; epidemiology and etiology.
Details: Two, 15-min filmstrips with audio cassettes.
Synopsis: Part one illustrates the reasons for using 'uppers:' to diet, to stay awake, to attain an athletic advantage. Although doctors prescribe these drugs for legitimate reasons, many people use them for their psychoactive effects, some in such quantities they can neither eat nor sleep. Many exhibit violent behavior and paranoia. Part two illustrates the use of 'downers:' to help people sleep, to escape from pressure, and to get high. Many become addicted; withdrawal can be difficult and dangerous.
General evaluation: Very poor to poor (1.8). The filmstrips are boring and because of the out-of-date information should not be used.
Recommended use: None.

Recovery: A New Beginning

Number: 750.
Subject heading: Treatment and rehabilitation.
Time: 22 min.
Synopsis: A woman whose husband has stopped drinking is disturbed because her life is not coming together as fast as she had expected. A neighbor with the same problem comes by. They discuss their ideas and fantasies (humorously illustrated) about how wonderful life would be once their husbands became sober. They talk about the value of Al-Anon meetings and the need to be patient, because recovery takes time.
General evaluation: Good to very good (4.9). This well-produced film has good information, well-presented. It could lead to helpful discussions on dealing with a newly sober spouse. General broadcast is recommended.
Recommended use: With a resource person, the film would benefit spouses of recovering alcohol abusers.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

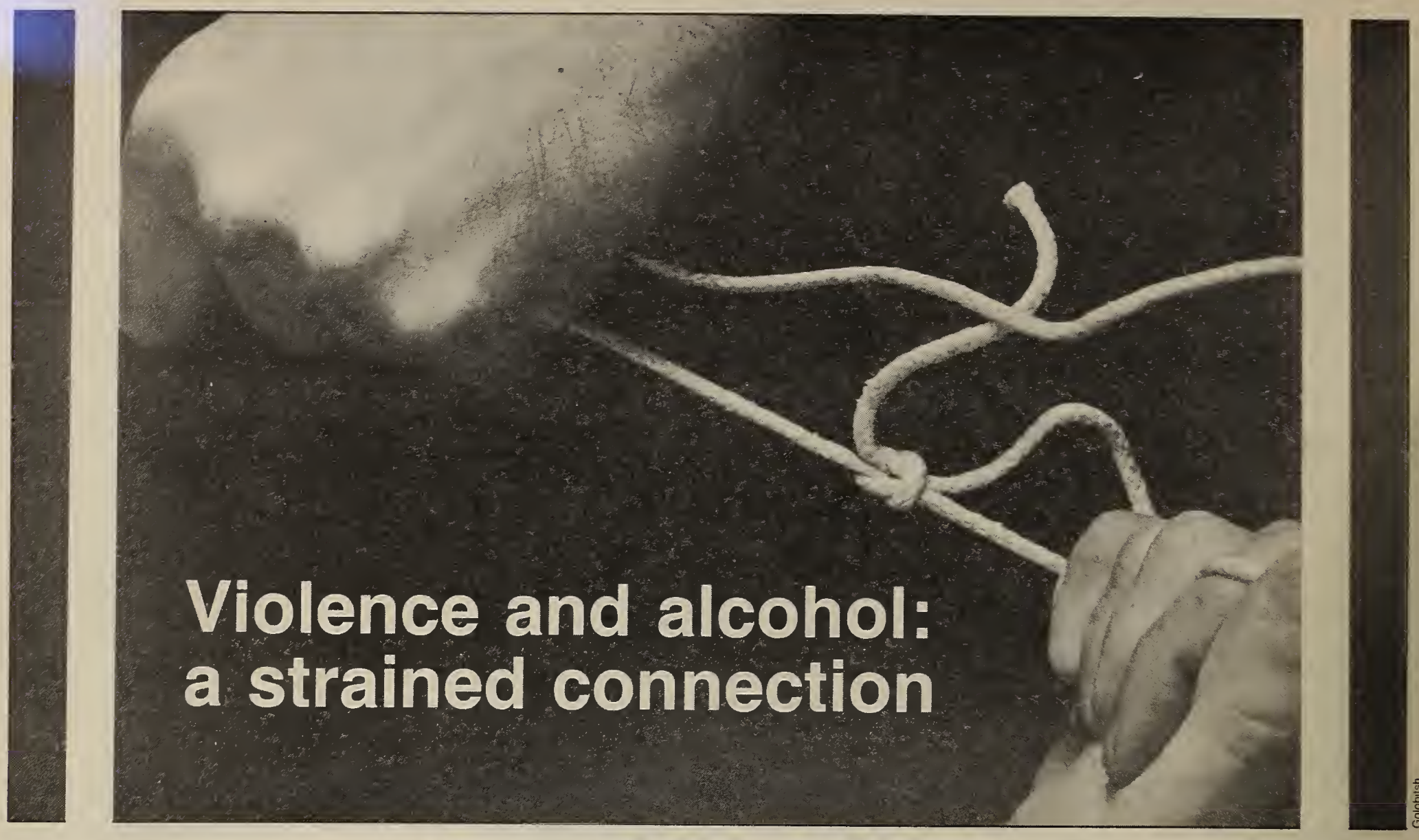
Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $24 per year
Air Mail: add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada



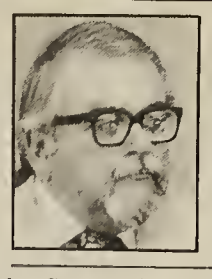
Violence and alcohol: a strained connection

Golobish

BOSTON — Alcoholism and domestic violence are inextricably linked by many alcoholism counsellors: treat the alcoholism, and the battering will stop.

This is a myth: the vast majority of batterers, usually men, are not alcoholics, and, while there may be occasions when they might batter while drinking, one is not linked to the other.

To try to get this message across to many in the substance abuse field is difficult. If denial is part of the armor of the alcoholic, it is also part of the armor of convictions of the alcoholism counsellor.



By Harvey McConnell

Some of the realities of domestic violence and battering were spelled out at the North American Congress on Alcohol and Drug Problems here by Steve Piatt, director of the Batterers' Group, Dayton, Ohio; Cindy Minton, group therapist at Dartmouth Hospital, Dayton; Mary Altpeter, coordinator of professional education, New York State Division of Alcoholism and Alcohol Abuse; and, Karla Digirolamo, executive director of the New York Governor's Commission on Domestic Violence.

Mr Piatt, a certified alcoholism counsellor for 15 years, who set up the Batterers' Group three years ago, said: "I have now seen 225 batterers, and, at most, only 10% would be classed alcoholic. A lot of the folks we work with have chosen to take a look at their drinking, but they were not alcoholic. There is absolutely no cause and effect that if you are going to drink, you are going to batter."

Mr Piatt and Ms Minton, a certified alcoholism counsellor as well, make a number of presentations at various conferences on their work and their findings.

Mr Piatt: "We find more and more and more that the hammer is treatment for alcoholism, and everything else becomes a nail. Everything becomes an alcoholism issue. We don't see it as such."

Ms Altpeter echoed her colleague: "From the alcoholism counsellors' point of view, they tend to look at the domestic violence as a symptom of the alcoholism. I can't tell you how many fights I have had with alcoholism counsellors about alcohol being the sole source of domestic violence and that if you treat the alcoholism, the domestic violence will go away.

"That's not true at all. Alcoholism and domestic violence are two separate behaviors, two separate issues. If one ceases drinking, it doesn't necessarily mean domestic violence stops."

Ms Digirolamo pointed out some men only abuse when they have been drinking and others never abuse when they are drinking. "There are a whole lot of questions, and it takes a much more careful and individual analysis of the family dynamics before we get an answer.

"I think looking for one answer, that alcoholism causes domestic violence — which has been the *forté* of the movement — is wrong. And, it is going to hedge you away from any realistic understanding of the complex dynamics of the family."

Mr Piatt said most of their referrals are from the courts, but they will admit people to the program whether they can pay or not. In the three years of the program, they have developed a system of long-term group therapy which focuses on such things as the cycle of violence, common characteristics of batterers, and the roots of domestic violence. The aims are to stop the violent behavior and for batterers to take responsibility for their actions.

Ms Minton said some of the root causes of the violence are an inability by batterers to be angry without being violent, to be able to identify one as a feeling and the other as a behavior.

"In addition, clients have difficulty in identifying and expressing their feelings; they just don't know how to talk about them. We see anger as a secondary feeling and that they don't know how to identify and express the primary feelings. They are also isolated emotionally.

"If you can overcome these, then they will not batter again."

Mr Piatt said he has been able to do only a scant follow-up, but the signs are that about 90% have not resumed their violent behavior.

In the program, the person being battered, usually a woman, goes through the educational series "to see what we are up to, to see what their mate is going to focus on, and to do some self-diagnosis.

"In fact, we have found about 40% of the time that there is dual battering going on. An action may have generated out of a reaction, but she is a batterer in her own right. This is something else a lot of people don't want to hear," said Mr Piatt.

Ms Altpeter noted that the literature on the problem is unclear: there is a range of 20% to 80% of an association between domestic violence and alcohol use.

"But, the jury is out as to exactly what is the causal relationship, *if* there is one at all. I know many in the alcoholism field think there is a causal relationship, but the literature doesn't support that. Our finding is that in many of the studies, the sample size is too small to generalize. This is why we are so hesitant to make generalizations."

Ms Digirolamo said domestic violence, or spousal abuse, occurs in between 10% to 20% of all marriages, legal or common-law. The most frequent victims are women: in New York state, records show there are 17 women to every man applying for relief, although the figure could be higher since many men are reluctant to seek help.

New York police are given training in handling domestic violence, and the stated policy is to arrest. Ms Digirolamo: "There is to be no questioning, no negotiation or mediation."

However, her experience in riding with the Albany police put things in a different perspective.

No simple answers

"What I learned is that there are no simplistic answers because the kinds of needs the families of domestic violence have are much broader and much more varied than simply a shelter for her and a batterers' program for him."

What brought this message home was the case of a low-income family the police were called to three times on the same night. Ms Digirolamo and the police were sure they had been using alcohol or other drugs, "but the domestic violence they faced was not the primary problem.

"Their primary problem was whether they were going to have food on the table tomorrow and a place to live next week."

Ms Digirolamo said there has been great hesitancy in the domestic violence field in talking about victim characteristics and whether the victim might be an alcohol or other drug abuser.

"We have tended not to discuss these issues because victims have been historically blamed and held responsible for being the victims of domestic violence."

She says the pendulum has moved too far in some ways, with no talk now about the role the victim may have in the abuse.

Ms Altpeter added: "Some people don't want to use alcohol as an excuse for behavior. On the other side, there is the idea the battered woman deserves it. There are a lot of attitudes held by society generally, as well as by counsellors, about what the problems are and what the people are about."

Ms Digirolamo said there is a debate in the domestic violence field at the moment "whether this is an inter-generational phenomenon. Some research shows boys who come from violent homes are at greater risk of becoming batterers.

"I also think there is some supporting evidence that girls from violent homes are more likely to become victims of domestic violence. The research is sketchy."

Mr Piatt said the program has found 75% of the 225 batterers studied "either received or viewed violence as kids."

Issue of power

Ms Digirolamo: "The key to battering seems to be an issue of power control. It relates to the psychological violence. The crucial factor in a violent relationship is the nature of the power relationship between those individuals.

"The abuser maintains the power in the relationship, through physical force, psychological coercion, or a combination of a whole variety of things."

In some relationships, the cycle of violence increases in severity and frequency, injuries get worse, and the violence seems to collapse into itself at some point. There is no longer a 'honeymoon' period, and psychological terrorism may be rampant.

"Violence knows no class or culture. It is probably one of our few real equal opportunity kind of things," added Ms Digirolamo.

She said the goal is to "empower women to take control of their own lives and to live violence-free lives, to let battered women make decisions in their own lives."

Ms Minton said most families in the Dayton program have not yet broken down. The policy is to treat anyone who needs help, "and we don't get a skewed picture because of that."

Mr Piatt, who deftly fielded hostile questioning from members of the congress audience who did not want to accept that alcohol and domestic violence are not linked, later said: "It is still discouraging for me to come to an alcohol conference and to hear so much tying alcoholism and battering into the same thing. It is just not true.

"I am going to have to go back and sit down with 20 batterers, only one of whom is an alcoholic, and say, 'You know, the perception of you all out there in the community at this conference was that you are alcoholic.' That's discouraging."

THE BACK PAGE

Marijuana — the issue then and now

By Harvey McConnell

SAN FRANCISCO — What a difference a decade makes.

Ten years ago a conference on marijuana dependence would probably have drawn few attendees, a yawn and a miss by newspapers and television, and ridicule from the vocal and political pro-marijuana lobby.

This fall, the swing of the pendulum was here for all to see: some 400 attendees came, about 60% of them women, and a majority of them in the treatment field and from California.

And, the media was here: three local, network television stations ran nightly reports on conference speakers, and both daily newspapers sent reporters and ran stories.

There were security guards at the door; one of the speakers, two weeks previously while making a speech on marijuana, had been harangued by a man later arrested and found to be carrying a pistol. The threat of picketing by pro-marijuana groups failed to materialize though.

"Quite honestly, when we decided to hold this conference, we really didn't know what the response would be. We are absolutely delighted," conference chairperson Julia Ross told **The Journal**.

Ms Ross said her experience with a model treatment program for adolescents, with total emphasis on family involvement, provided the impetus for the conference.

High potency marijuana available today is a different drug compared with the weak drug available in San Francisco's flower power days of 20 years ago.

And, the people here are sophisticated treatment people; they know the depth of the marijuana problem because they are trying to help those in trouble.

As for the threat of picketing, others attending the meeting pointed out marijuana is now a big cash crop in northern California and often violent means are taken to protect the crops. Adverse comments about marijuana are seen as a direct threat.

Conference speakers highlighted the absolute need for massive prevention campaigns: the fact is that the success rate in treating those addicted to marijuana is dismal.

Flower power to 1986

Marijuana Dependency conference coverage on pages 7/8

Vol. 15 No. 12 2nd Class Mail Reg No. 2776 TORONTO, December 1, 1986

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Getting drug addicts off needles a priority: Tennant

AIDS must supersede other drug issues

By Harvey McConnell

LOS ANGELES — Herculean efforts to stop intravenous drug use because of the AIDS epidemic should supersede every other drug issue in the United States and abroad.

"We may have the whole planet in danger from the spread of the AIDS virus in the next few years, and the number one priority is to do everything we can to get people off needles," is the chilling assessment of Forest Tennant, MD.

Dr Tennant is director of a number of clinics here and consultant to the US National Football League and the Los Angeles Dodgers. He and his colleagues have been carrying out a prevalence study of 500 addicts currently in treatment, to see how many are positive for the AIDS (HIV) virus.

Their previous testing found about 15% of the addicts antibody positive.

Dr Tennant expects he will find a similar figure or even higher in the current study of the US National Institute on Drug Abuse.

Most homosexual men will confine their sexual experiences to only a small group of the population, he points out; but, intravenous (IV) drug users generally have heterosexual relationships. In addition, many women IV drug users at times turn to prostitution.

"One has to be more concerned about the spread of AIDS to the general population from IV drug users. Everyone in the drug addiction field needs to get on top of this immediately," Dr Tennant told **The Journal**.

"We do have drugs in sports and industry and among teenagers," but the rising number of AIDS cases connected with IV drug use is more alarming.

He thinks crash programs are essential. Now.

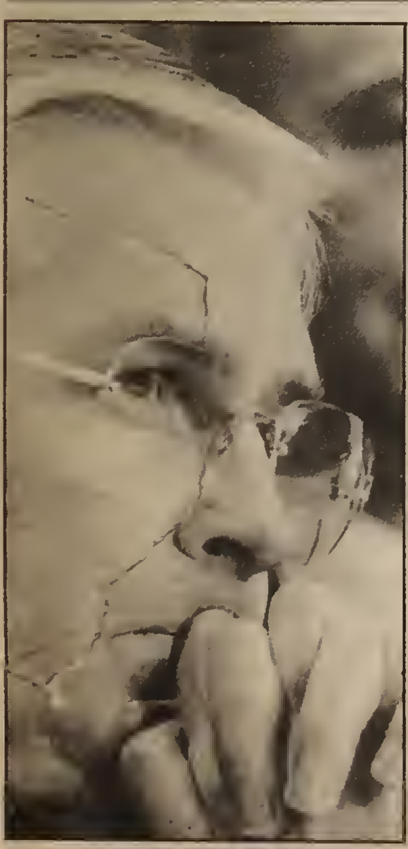
While giving addicts all the sterile needles they want is medically sound, it is a political quagmire, he says.

"The way to go, I think, is more methadone programs and programs using LAM (levo-alpha-acetylmethadol) which addicts have to take only three times a week to keep off heroin.

(See Aids, p2)

Tennant: crash programs

Epp aims for January delivery of Canada's new drug strategy



Epp: consultation, realization

By Anne MacLennan

OTTAWA — Canada's Health Minister Jake Epp will unveil a federal strategy on drug abuse prevention and control early in the new year.

"I personally have targeted around the end of January," he said here after a speech to an international conference on health promotion in industrialized countries.

Mr Epp said he has been working on the Canadian strategy with voluntary organizations, addictions foundations, and the provinces.

Although alcohol and tobacco were discussed in the report he presented to delegates — Achieving Health for All: A Framework for Health Promotion — illicit drugs got short shrift.

In his address, however, Mr Epp said the strategy on illicit drugs is in response to the initiative of the international community which, through the United Nations, has emphasized the need for broader global cooperation to suppress demand and control supply of illicit drugs (**The Journal**, June).

In the run-up to a high-level, international meeting on drugs in Vienna next June, there has been pressure on countries to develop and come to the meeting with their own national strategies in place — for now, Canada has none.

"Consultation with the provinces (**The Journal**, November) and cooperation with the international community will make our efforts more effective," Mr Epp said.

Development of Canada's strategy is lodged with an inter-ministerial secretariat, set up in the autumn and working under severe pressure to be ready for June.

He emphasized to conference delegates that Canada's drug strategy is not "simply a response by the government to a high-profile media issue. I meet too many parents and I see too many people who are not particularly impressed by the narrow view of the media as to whether or not there is a problem. There is.

"In fact, there is hostility to the media, because they have not come to the realization of what is happening in our school corridors, on our sidewalks, in our homes."

The conference here was sponsored by the UN World Health Organization, Health and Welfare Canada, and the Canadian Public Health Association. Some 200 invited delegates from around the world looked at health promotion.

Depression: why Irish eyes aren't smiling

CORK, IRELAND — A study of Irish factory workers and their bosses shows life is tougher at the bottom.

The executives may be under considerable pressure, but it's blue-collar workers who are getting the ulcers, suffering from depression, and turning to the bottle.

The study, conducted by John Hurley of Dublin's National Institute for Higher Education, indicates frustration and stress increase progressively from the boardroom down to the shop floor. That's not to say management escapes from work-related health problems.

Managers are more likely to develop circulatory and heart problems, says Dr Hurley, who points out his study shows employers and blue-collar workers develop strikingly different diseases and have different anxieties. Indeed, people at the bottom of the pay scale have 20 times the number of ulcers than do employees who are part of the management structure.

"Management is under strain to make the right decisions. They bear the weight of responsibility and suffer doubt and anxiety," said Dr Hurley, a specialist in occupational psychology.

"As a result, executives are far more likely to suffer from heart disease than lower-paid members of the same firm."

Those on the factory floor do not suffer the same incidence of heart disease, although they eat more greasy foods which have been

(See Most, p2)

NEWS

Briefly . . .

Post script

TORONTO — Canadian doctors are planning to remind members of parliament in a blunt way about the dangers of smoking. The physicians will send them a black-bordered posteard each time one of their constituents dies of a smoking-related disease, says *The Toronto Star.* Based on a similar British plan of several years ago, the card reads: "I regret to inform you that one of your constituents has died due to the adverse effects of tobacco smoking." The organization, Physicians for A Smoke-Free Canada, is providing the eards free of charge.

Border check

CALGARY — Foothills Hospital here is facing a surge of interest by employers wanting to test workers for drug abuse, reports *The Globe and Mail.* The hospital has fielded calls from about a dozen companies since United States President Ronald Reagan began his anti-drug abuse crusade in August, says the head of the hospital's drug-testing centre.

Commodity pits

WASHINGTON — Compulsive gambling on financial markets now comprises a small but rapidly growing percentage of those seeking professional help for gambling addiction. And, Gamblers Anonymous in the United States has now added stocks, options, and futures contracts to its list of forbidden fruits for compulsive gamblers, reports *The Washington Post.* The self-help group acted after a survey of 201 members revealed 8% were engaged in speculating on a weekly basis, while another 22% had done so at some time. Ten years ago, a similar survey revealed only one person mentioning commodities as a form of gambling.

Dogging it

TORONTO — Complaints of drug squad raids damaging homes of innocent people could be eliminated if police used trained, drug-detecting dogs, says Metro Police Commission chairman Clare Westcott in *The Toronto Star.* "With dogs, you don't have to wreck the place. They can sniff drugs out. Without them, there's no way to know if there are drugs in a mattress unless you cut it open."

Hold the olives

BOSTON — Toothpicks speared into olives and onions in mixed drinks can be dangerous, say two researchers in a tongue-in-cheek letter to the *New England Journal of Medicine.* They say a man who quickly consumed a Gibson — made from gin, ice, and vermouth, and garnished with cocktail onions on a toothpick — was frantic when the toothpick floated into his mouth and got stuck into the channel leading into his nose. The researchers, as quoted by *United Press International,* condemn "hasty ingestion" of these drinks, but also report the victim was able to get help at a local hospital.

Football players join hockey peers to help RCMP fight drug use

By Terri Etherington

TORONTO — Sports stars from the Canadian Football League (CFL) have joined their peers from the National Hockey League (NHL) to tell kids drugs and sports don't mix.

Sergeant Michel Pelletier, Drug Awareness and Education National Coordinator for the Royal Canadian Mounted Police (RCMP), told **The Journal** three new public service commercials have been made.

These are a continuation of a program started in 1980. Now, the program, which includes a speakers' tour of schools and youth groups for the athletes and RCMP officers (**The Journal**, November, 1985), involves 40 to 50 sports stars.

This year, for the first time, football stars have participated: Nick Arakgi of the Montreal Alouettes, Eugene Belliveau of the Calgary Stampeders, and Montreal minor football player Bernard Guay.

The professionals say they probably wouldn't be in sports today if they had used drugs and invite the youngster to "join the team and say no to drugs."

The two videotaped NHL messages are narrated by former Montreal Canadien Jean Belliveau, in French and English, and were filmed at the NHL All-Star game in Hartford, Connecticut last year.

One takes on an international flavor. Jari Kurri in a Team Sweden sweater; Mats Naslund, representing Team Finland; Rod Langway, Team USA; and Michel Goulet and Paul Coffey, Team Canada bring the message, "No matter who you are, no matter where you are from, you can join the team against drugs," says Sgt Pelletier.

Voice-overs, in Swedish, Finnish, and English, have been made by the players. Tapes will be presented to the ambassadors from these countries for use abroad.

Other NHL players involved in the commercials are Wayne Gretzky, Larry Robinson, Dale Hawerchuck, and Sylvain Turgeon. But, says Sgt Pelletier, many more are involved in bringing the anti-drug message to kids.

Sgt Pelletier: "The success of prevention campaigns is harder to analyze than enforcement efforts."

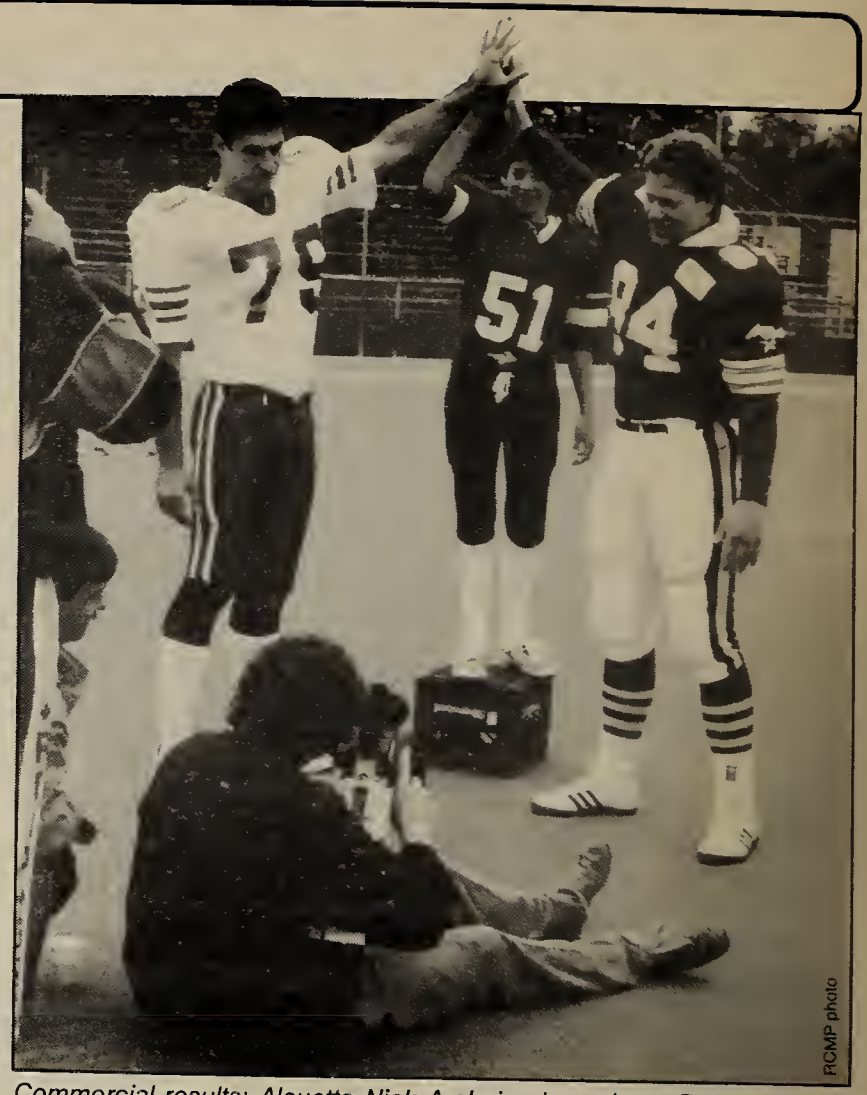
He participated in more than 500 lectures last year, but "how many people we have convinced not to use drugs," is still in question.

Success can only be measured in public support and public awareness of the program, he said.

At an unveiling of the new public service announcements, Solicitor General James Kelleher said the program is "the result of the sincere desire of the NHL and the CFL executive and players to do their part in urging Canadian youth to resist peer pressure to use drugs.

"Along with drug enforcement, must come drug education," Mr Kelleher said.

"Professional and amateur athletes represent an excellent way to reach youth with a message they'll listen to. The athletes are role models and an inspiration to Canadian youth. When they talk, youth listen."



Commercial results: Alouette Nick Arakgi, minor player Bernard Guay, and Stampeder Eugene Belliveau film for the RCMP

People must forget biases, says Tennant

AIDS called bigger risk than nuclear war

(from page 1)

"We still have a terrible bias about using narcotic substitution. We have this naive idea we can cure heroin addicts in great number, and we can't.

"It is ridiculous not to be using LAM even though it is in the experimental stage and is still considered an orphan drug. It needs to be moved up to a priority drug."

Dr Tennant would like to see, within the next six months, every IV drug addict in the country given the chance to take methadone, LAM, or whatever they will take to get them off needle use.

Dr Tennant recalls that in the early 1970s, "we saw something like AIDS in the addict population. We saw a large number of addicts who looked like they had Hodgkin's disease — or lymphoma, although this turned out to be benign. We started to realize they (addicts) had all kinds of immunological abnormalities, rheumatoid factors, complement fixation, and abnormal proteins in their blood.

"Looking back now, what we can see is that the IV drug use people have always been impaired from an immune point of view."

Dr Tennant, who also holds a doctorate in public health and is associate professor at the University of California at Los Angeles, added, "Let's keep worrying about teenagers and let's worry about the worker who is on marijuana and let's worry about the athletes and let's worry about the foreign countries and let's not forget about cancer and heart disease.

"But, let me tell you, move AIDS to the top. People have to forget their biases: we must do everything about the IV drug users."

Dr Tennant is putting on the back burner some of his current research studies into cocaine addiction and nicotine studies to concentrate his efforts on IV drug users.

He does not think he is being melodramatic: "We may be talking about a risk to the lives of every one of us. Frankly, we may be looking at a greater risk than nuclear war, because we all may die from this disease.

"Historically, there have been races which have disappeared, and we don't know what happened. Possibly a virus knocked them out."

Most serious drug problem in Ireland is alcohol abuse

(from page 1)

linked with coronary illness.

"There may be dietary factors at work here, too, but lower-paid workers tend to suffer from ulcers and depression," said Dr Hurley.

In many cases, the depression seems to lead to alcoholism.

Alcoholism is a growing problem in Ireland especially among the young, the unemployed, and women. According to the latest government figures, alcohol abuse is the most serious drug problem in the country.

Dr Hurley's study suggests workers often deal with machinery which can seem to dominate their working lives and control them. This leads to a gradual loss of self-esteem and happiness.

"Children have small time-perspectives and can carry out repetitive tasks with satisfaction. But, adults have a much longer time-perspective, and adults can see themselves working with the same machine for 20 or 30 years with no prospect of advancement," he said.

— coming up in —

THE JOURNAL

- **First Canadian CoA national conference**
- **Symposium reports on young drivers and alcohol**
- **1985/86 RCMP Drug Intelligence Estimate**

US to spend $1.7 billion to beef up drug fight

WASHINGTON — A $1.7 billion bill passed by the United States Congress to fight drug abuse has been signed into law by President Ronald Reagan.

Among the provisions are a $200 million grant to states for drug prevention programs in schools, additional funds for drug abuse treatment and rehabilitation, drug research, clinical training programs for drug abuse professionals, and for counselling and medical services to alcohol and other drug dependent offenders.

More funds will go to the Coast Guard, Customs Service, and Drug Enforcement Administration, and for additional aircraft and radar surveillance equipment.

Penalties have been increased for manufacturing illicit drugs and for drug-money laundering.

NEWS

Threat of AIDS infection recognized

Britain provides free syringes to drug addicts

By Alan Massam

LONDON — The British government is going ahead with a controversial plan to supply drug addicts with free syringes, despite cries from some influential voices that it will escalate abuse.

The decision, indicating the government's recognition of AIDS as a greater risk than opiate addiction, follows a heated debate within the corridors of power.

Just-retired health minister Barney Hayhoe is strongly opposed to supplying syringes to addicts, whereas his successor, Tony Newton, is said to be in favor.

He has undoubtedly been influenced by representations from the Department of Health and Social Security's (DHSS) chief medical officer, Sir Donald Acheson, who is taking personal responsibility for developing a strategy for checking the AIDS problem.

Sir Donald told a Pharmaceutical Society of Great Britain conference in Jersey the sharing of infected needles is the most important non-sexual way of spreading AIDS. He said there are now an estimated 40,000 AIDS carriers in Britain, and 465 people have actually been diagnosed as suffering from the disease.

Mellor: 5,000 convictions

An addict could be infected with the virus after only one injection from a contaminated needle.

The anguish suffered in government departments about the free-needles issue (**The Journal**, April) was later illustrated when Home Office Minister David Mellor told the conference the number of registered drug addicts in Britain is rising steeply.

There has been a 25% increase this year and a 30% increase last year.

"Over 5,000 traffickers and suppliers were convicted (in 1985), 800 more than in 1984. It is clear that the courts have not faltered in the war against the drug traffickers," Mr Mellor said.

Sir Donald told the conference: "We have spent much time recently discussing whether increasing the availability of needles and syringes would assist in reducing the spread of infection with AIDS. The evidence from Amsterdam (**The Journal**, October) has been encouraging. We would need to have it clearly established, of course, that the supply of injecting equipment is regarded as a professionally acceptable act."

Sir Donald said the government had hitherto rejected the idea on the grounds it would be wrong to encourage addicts in an undesirable and illegal act. But, the prevailing DHSS view is that preventing the spread of AIDS is the overriding priority.

William Harris, MD, director of Europe's largest clinic for the treatment of sexually transmitted diseases (at St Mary's Hospital, Paddington), said the spread of AIDS among drug addicts in some cities is "alarming." It is now estimated 50% of hard drug addicts in Edinburgh are carrying the virus.

This compares with only 5% of addicts carrying the virus in neighboring Glasgow where needles are easier to obtain.

Dr Harris said addicts are an important, high-risk group who could spread AIDS into the general population because of their tendency to raise money by prostitution.

There is now no doubt about the heterosexual transmission of AIDS, and all major centres for treating AIDS in Britain are now seeing heterosexual sufferers.

Provinces ignoring BAL law changes

By Betty Lou Lee

WINNIPEG — Implementation of new federal legislation to allow compulsory blood alcohol testing has been disappointing to the Canadian Medical Association (CMA).

Douglas Geekie, CMA director of communications and government relations, used terms like "pathetic, sad, non-existent, and hopeless" to describe enforcement of the changes by the provinces.

The Criminal Code of Canada was changed a year ago to allow people to get warrants, by telephone if necessary, authorizing the taking of blood samples (**The Journal**, March).

The move, for which the CMA lobbied for years, is designed to cover situations in which a driver involved in an accident either receives, or feigns, injuries so that police can't get a breath sample.

But, a Canada-wide survey conducted for the CMA in April and May showed little uniformity or coordination in implementation.

It found a "hodge-podge" of complex blood sample certificates in various jurisdictions, confusion about whether samples should be taken under the Criminal Code or provincial legislation, failure to establish fees for taking samples and subsequent court appearances by doctors, and failure to use the approved blood sample kits.

Before the changes, Doug Lucas, director of the Ontario Centre for Forensic Sciences, predicted 1,500 requests for blood samples a year in Ontario.

In the first three months, his centre handled only 65 cases from provincial and most local police forces. Only two involved telewarrants. He then scaled his estimate down to 500 (compared to 50,000 breath tests a year).

At least four provinces — Saskatchewan, Nova Scotia, Prince Edward Island, and New Brunswick — had made no provision for telewarrants, although the law says the blood sample must be taken within two hours of an accident.

And in Quebec, police were not using the containers authorized for the blood samples.

In Manitoba, some hospital boards are worried because the legislation does not specifically protect them from civil liability, as it does doctors and other staff members authorized to extract blood.

Under the federal law, two samples are taken, one for the police and one for the patient, in case there is a dispute about the analysis. But, there is no consistent procedure for storing the patient's sample. In some areas, it is kept by a forensic lab; in others, the police keep it.

No provision has been made to collect and collate data to assess the results of the changes on drunk driving.

Provincial medical associations are being urged by the CMA to pursue the issue with provincial governments, and the federal Department of Justice is being encouraged to establish a system of collecting data and researching the impact of the changes.

'Grass signs' close parks to US public

WASHINGTON — The United States Department of Agriculture has closed nearly one million acres of park land to the public because of dangers posed by marijuana growers.

Guns, booby traps, land mines, and guard dogs are used to protect illicit patches. The department has now been given authority to arm special teams of US Forest Services agents and to give them more authority to deal with the problem.

Officials said the problem is worst in Arkansas, California, Florida, Missouri, and North Carolina, but it is spreading to other states. Because the enforcement powers of agents are limited, their only recourse is to close off areas of suspected marijuana growing.

Illegal growing is not confined to rural areas: marijuana was found under cultivation in this urban area this year, and one ranger nearly stepped on a trip-wire to a shotgun.

INSIDE OUT

A glimpse of the Absolute

As I start my third year of staying sober, this strange sensation hits me strongly: I am beginning to be faithful in my fashion.

What began originally as an utterly astonishing proposition — winding my way through the day without wanting a drink — now seems an obviously acceptable reality, like the necessary notion we all have of putting aside enough money each week to pay the rent at the end of the month.

No, this time, as the second anniversary hove into view, I could see a difference from that first cataclysmic birthday.

That first one — what can I tell you? It was, I suppose, the greatest day of my life, in many ways.

I spent much of it going off into isolated corners, away from the view of people who know me, to cry for joy, to weep from a simple, boundless gratitude.

I bought flowers that day for a friend who had helped me. I walked so proudly, so humbly too, with them through the streets of the city where I live, and I stormed her office and gave her those roses with a roller-coaster feeling that I had just returned from far away, like a triumphant, blood-stained Crusader after a year-long siege in a very foreign land, holding high in my hands the banner captured from the enemy.

Somehow, as I looked around for her desk (and, yes, the sun was shining through the windows of her office) I knew irrevocably that I had made it through, stayed the sometimes frightening course.

I hadn't fled from the battles, even when I was wounded and terrified, all ready to have given anything to have been permitted to cast off the terrible strictures of the vow I'd taken so shakily, with such little concrete hope, when I'd gone off to this particular, necessary war.

It was a day without precedent for me. No matter how heavily I was still being bombarded by wave after wave of the weaknesses I had yet to look hard in the eye at, no matter that some of the time I still felt confused and down and without a sense of an ongoing optimism — I had so far to go before I would begin to become whole — I had now at least this one tremendous victory in my life. I was swept away in a sea of euphoria.

That one degree you are straddling is like being on the longest tightrope in the universe

But this year, yes, this second birthday is different.

It is so much quieter, the emotional fireworks are much less bombastic, the sound of triumph roaring in the ears is less resonant.

It isn't merely that the novelty is wearing off; it isn't, certainly, that I am beginning to take sobriety for granted. It has been, I guess, like the subtle shifts that take place in any relationship, if you will.

For what begins in glory and headiness becomes deeper, beyond words, a part of the marrow in the bones of the soul.

The gushing river exploding down its course, smashing into stones, washing over its banks, bubbling always like champagne, roaring endlessly, proclaiming itself to all living creatures observing its perpetual frothy vitality, becomes an almost silent stream, moving slowly, placidly, but inevitably onwards, stately, reserved, dignified, deeper, without the pushiness of boasting.

So, I have found a calm descending on me in the second full year of staying straight; a still centre hovers somewhere inside.

I have found a perspective, a balance, that sometimes seems to be the property of a loving couple who have been together through a lot of hoops in their time and haven't lost their mutual centre of gravity.

Yes, I have found being steadily sober is like a good marriage; it's self-contained and doesn't need to be constantly advertised, shouted about, pointed at by others.

I have found staying straight is a poor man's glimpse of the Absolute. It is always there, no matter what the temporary circumstances of your life are, if you are dancing on the top, or flailing away on the bottom. It is unchanging, monumental. It is awesome. It is a light always shining. It's an ultimate commitment, a grand, shattering "Yes" to living a life unclouded.

For some of us, it is what we have instead of God; for others, it is God, or at least a clear, never-wavering connection to Him, a door through which we can see Him.

To say staying straight is a spiritual affair is not to get maudlin, not to become preachy about what's involved; it's only to state what is real.

For when a person goes from one Absolute — the absolute fact of addiction — and turns around 359 degrees to another Absolute — the absolute fact of saying yes to sobriety — a mighty, shattering, spiritual revolution has taken place.

And so, you straddle that one flimsy, scary degree, with a free will to go back to the other Absolute at any time, back to 360 degrees again, back to the horror. And, that one degree you are straddling is like being on the longest tightrope in the universe.

But, you continue to walk it, as long as you can, no matter how frightening it is to be so high up, with your knees shaking, with your palms sweating, with your eyes tearing over, with your loneliness, without the net below, because that's what freedom really is — a chance to say yes, a chance to say no.

Merry Christmas from a tightrope walker.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Another FAS marker

Upper airway obstruction can be a definite problem to watch for in some children with fetal alcohol syndrome (FAS). Three physicians from San Francisco and Fresno, California have reported the case histories of three FAS children who also had definite upper airway problems. In all cases, the obstructions caused significant morbidity, leading to severe obstruetive apnea and respiratory arrest in two infants and chronic hypoxia in two cases. Drs Anna Usowicz, Mahin Golabi, and Cynthia Curry say the chronic obstruction may have contributed to growth failure because of the increased work with breathing. They also note that in two cases anomalies of the upper airway caused severe feeding difficulties. They conclude recognition of this aspect of FAS is important to help prevent serious complications associated with the condition, obstructive apnea, sudden infant death syndrome, and pulmonary hypertension.

American Journal of Diseases of Children, October, 1986, v.140:1039-1041.

Laughing gas no laughing matter

Evidence exists that nitrous oxide (laughing gas) is an addictive agent through involvement of the endogenous opioid system. M. A. Gillman, DSc, of the South African Brain Research Institute, Johannesburg, drew this conclusion after evaluating existing studies of animals and humans that point to nitrous oxide interacting with the endogenous opioid system to produce addictive behavior. For example, morphine has been shown in animals to decrease abstinence symptoms induced by exposure to nitrous oxide, and the narcotic antagonist naloxone can precipitate such symptoms. But, Dr Gillman says it would be premature to state that nitrous oxide can induce a true opioid addictive state. Looking at the 32 cases of nitrous oxide abuse reported to date, he says a number of them showed signs of neuropathology, as well as the development of tolerance and psychological dependence. Noting that professionals, especially dentists, who use the drug in their practice are at greatest risk of becoming dependent, Dr Gillman concludes nitrous oxide "should be placed under stricter control, and ways of restricting the abuse potential of industrially available nitrous oxide should be sought."

The American Journal of Medicine, July, 1986, v.81:97-101.

Tongue cancer tied to smokeless tobacco

Rising mortality from cancer of the tongue among young, white males in the United States has been blamed on the increasing use of smokeless tobacco. Robert Depue, PhD, of Rockville, Maryland, evaluated the cancer statistics in white males from 1950 through to 1982 with data from the US National Center for Health Statistics. Dr Depue found the mortality from tongue cancer for the 10- to 29-year age group more than doubled in the study period. He said: "The observed increase in mortality from tongue cancer is consistent with an increased use of snuff by children and adolescents." While no similar upward trend in mortality was seen for cancer at other sites in the mouth, Dr Depue notes this is not surprising. Cancer of gums and cheeks often are not listed separately on death certificates but rather are classified as "mouth, not otherwise specified," along with many lip cancers that are caused by sunlight. On the other hand, tongue cancer is usually treated as a distinct entity that is more likely to be correctly identified on death records.

The New England Journal of Medicine, September 4, 1986, v.315:647.

Pat Rich

US colleges 'the bad guys' in alcohol fight: DuPont

By Harvey McConnell

BOSTON — Curbing teenage alcohol use is the bedrock of drug abuse prevention, and the prime target in the United States is "the baptism in beer" of college students.

In a swinging attack, Robert DuPont, MD, president of the Center for Behavioral Medicine, Rockville, Maryland, laid it on the line at the North American Congress on Alcohol and Drug Problems here.

The critical question in the present drug abuse epidemic is adolescent alcohol use. "That is the toughest issue, and if we don't win that one, the rest of it is over, in my view."

Dr DuPont: "The institution in society which is absolutely the worst of all institutions that 'ain't doing the right thing' —the number one bad guy — is the college.

"When kids go away to eollege, it is a baptism in beer. It is the most incredible experience we put kids through. And, the more sophisticated the college, the more that's going on."

He says the defence of university presidents and their supporters for not doing anything "frankly makes me sick."

Dr DuPont realizes "it has a very unmodern sound," but it is true to say "society really needs to organize itself to protect kids, because during that teenage period the capacity of many kids to think through the consequences of their behavior is really quite limited on a biological basis."

He likes to think of prevention as a "caring environment that is respectful of the wings as well as the roots of the young people, but which really accepts adult responsibility for protecting the kids during particularly vulnerable times."

His years in the field and his current work with teenagers leaves him in no doubt: "The ultimate prevention goal is to put a proteetive barrier around the ages of 12 to 20 years, when most of the drug use begins. It is a very simple goal, and, if we don't do that, we are not going to be able to solve this problem. The power of the drugs is too great; the biology is too great.

"The lovely, romantic idea that if you just love the kids enough and trust them, they'll be fine is not right. It won't work because of the power of these drugs. They are too good."

Yet, the past months have seen stunning changes.

"I never thought I would see the day at the federal level where there would be vying for activity in the drug abuse field (**The Journal**, October), people would talk about putting what are very large sums of money into the drug field.

"There is much more awareness today that the problem is using chemicals to get high: the problem is intoxication, not a particular drug."

DuPont: protective barrier

On the issue of urine testing for drugs, Dr DuPont declares: "If it is in my urine, it is in my brain. Never, never, never mind whether I used it five minutes ago or five days ago. Opponents of drug testing are clearly confused about that: they say what you are doing is identifying previous drug use. That is not the point; the point is that it is not in your urine unless it is in your brain."

Dr DuPont acknowledges many things being proposed — urine testing, restrictions on parole and probation, raising the drinking age — may sound "harsh, punitive, hostile, and negative. It isn't any of that: if you turn away the drugs, what you have left is hope, human capacity, families that can work for each other, and communities that can function."

Non-invasive indicator

Blood test for liver disease coming

TORONTO — A blood test to detect liver disease is under development at the Clinical Research Centre at Dalhousie University, Halifax.

It measures the level of the hepatic enzyme aryl hydrocarbon hydroxylase (AHH), which is lower in cirrhosis.

It could become a non-invasive indicator of progression and/or severity of liver disease, Theresa Peterson, MD, a doctoral fellow, told the annual meeting here of the Canadian Society for Clinical Investigation.

Monocyte AHH activity in peripheral blood from 20 patients with various types of liver disease, confirmed by biopsy, was compared to that of 19 volunteers with normal liver function.

Not only was AHH significantly lower in the disease group, but there was a significant difference between those with early stage disease and those with established cirrhosis.

No such difference between early and late disease could be found with the standard liver function tests now in use.

In two patients, the results of these tests were normal, although AHH levels were depressed.

Biopsies had shown they had disease induced by methotrexate, a drug used against cancer and severe psoriasis.

Dr Peterson said the test may be useful in monitoring progression of liver disease, as well as detecting it. In methotrexate patients, this now requires repeated biopsies.

HOWELL

The leaning tower of Toronto?

I've just returned from a brief sojourn in Italy, jet-lagged and saddle-sore from a meandering DC-10 ride across half of Europe and all of the Atlantic.

The slightly stale news that greeted me in my collected stacks of *The Globe and Mail* was not unexpected: in my absence, the Conservative (Tories) and New Democratic Party (NDP) opposition in the Ontario legislature conspired to thwart the minority Liberal government's plans to market beer and domestic wine in corner stores.

They did this for the usual reasons; such sales would lead to the breakdown of The Family as we know it, not to mention more alcohol-related motor vehicle accidents, domestic violence, and juvenile delinquency.

They looked Chaos in the eye, and did the only thing they could do: they opted for Order.

I suppose I should have been heartened by the fact a good proportion of the Liberal caucus, including Premier David Peterson, were so embarassed by the party's flirtation with Chaos (it was a serious flirtation; beer and wine in corner stores was the main plank in the last Liberal election platform) that it didn't even show up for the recorded vote.

I should have been heartened because, to paraphrase the Good Book, there is more joy in heaven over one sinner that repenteth — even a Liberal sinner — than the ninety and nine just persons (Tories and NDPers) that need no repentence.

But, rather than being heartened, I was somewhat . . . discombobulated. I blame this on jet-lag. After all, I am an Ontarian born and bred. I know in my heart of hearts that it is only the stern discipline of the Liquor Control Board of Ontario (LCBO) and the Brewers' Retail Corporation that protects us from licentiousness, lasciviousness, and worse things that don't even start with the letter L. I know in my heart of hearts that were it not for these two institutions, Toronto's CN Tower would have ended up looking like the bell tower in Pisa, or worse.

But all the same, it is discombobulating to leave Italy, a country where The Family appears to be surviving quite nicely despite the fact alcoholic beverages are retailed in corner stores like rice and potatoes, and arrive in a province where The Family is doing rather poorly despite the fact that the authorities consider that the natural adjective for rum is 'demon' and govern themselves — and us — accordingly.

It is especially discombobulating in view of the fact that although the Italians retail alcoholic beverages as casually as rice and potatoes, they market them with — to our eyes, at any rate — unseemly flair. In the cities, Italian retailers of spirits are not content with offering mere rows of bottles; many retailers back-light them with fluorescent lighting so the various colored bottles actually glow. The net effect is a kind of Las Vegas extravaganza of neon color.

It is difficult to go, in the course of a few short hours, from a world of neon-booze to a world where the words demon rum still have some meaning.

One cannot help speculating: at what point does a society get locked into its social and cultural preconceptions about alcohol availability and drinking practices, and at what point are you stuck with what you've got?

In other words, does Ontario's Methodist and Presbyterian past forever govern its future? What actually would happen if we were exposed to Italian-style ethanol ubiquity? Would the CN Tower lean, would The Family collapse? Or could we take beer and wine in corner stores — or leave it?

Personally, I think we could take it or leave it. At least, I would like to think we could take it or leave it.

I would like to think that we have progressed to the point where we could, in the words of the advertisement "become our own Liquor Control Board."

But, perhaps, jet-lag has influenced my thinking. Perhaps, her majesty's loyal opposition knows best; perhaps, Ontario needs the LCBO as much as Geneva needed John Calvin.

By Wayne Howell

NEWS

Stigma problem could reappear, says public health official

New political 'war' on drug use could backfire

BOSTON — There is danger that the current, vigorous attack on drug abuse in the United States may bring back the stigma many have battled to remove.

This is the opinion of Kenneth Eaton, Washington representative of the Michigan Department of Public Health and a long-time official in the drug abuse field.

While much of what is happening today has great potential and gives him good feelings, "some of what is happening now has the prospect of renewing the stigma that we all fought so hard over so many years to help eradicate."

Some of the discussions have begun to deny the "illness" concept which has been used so successfully in helping those with drug problems, he adds.

Mr Eaton told the North American Congress on Alcohol and Drug Problems here that urine screening to get employees using drugs out of the workplace "may not pay attention to what is going to be needed for those individuals not to use drugs. We may be going back to 20 years ago."

Gus Hewlett, president of the Alcohol Policy Council, Washington, and a member of the same panel, said the drive by some to produce a drug-free society by the year 2000 "is a rather ambitious goal, and one has questions whether it is either feasible or possible."

He says, however, there is a practical and attainable goal: "For those who can drink and choose to drink, to do so in moderation, without guilt or fear; for those who choose to abstain, the same degree of freedom; and, for those who for whatever reason develop drinking problems, to recognize the problems at the earliest possible time and to get appropriate help. This atmosphere would result in reduction of alcohol problems."

Pop music star Corey Hart is lending a hand to the Manitoba Lung Association by speaking out against smoking. His message is styled in his own way: "I feel smoking is a serious threat to a person's health, and I want to help focus some attention on this real danger." The singer's support is backed by radio and television messages urging young people not to smoke. Corresponding newspaper and magazine advertisements are also appearing across Canada.

US otolaryngologists speak out — public lacks vital cocaine facts

By Paul Szabo

WASHINGTON — The association representing almost 8,000 otolaryngologists in the United States has taken a strong public stand on the dangers of using cocaine.

"The public must realize that cocaine kills," says David Fairbanks, MD, public information chairman of the American Academy of Otolaryngology-Head and Neck Surgery. Academy members not only treat many patients who have damaged their noses by cocaine abuse, but also use the drug as a topical anesthetic in their practices.

Dr Fairbanks contrasted clinical experience with cocaine as an anesthetic with recreational use of the drug.

A recent US survey shows that in the lifetime careers of 2,240 otolaryngologists, only 15 fatalities were reported, in contrast with the "thousands upon thousands" of deaths among recreational users.

But the study, conducted by the academy at Walter Reed Army Medical Center, Washington, DC, also points out that even using cocaine as an anesthetic in the safest circumstances can prompt adverse reactions, varying from hyperexcitability and diaphoresis (excessive perspiration), to convulsions and respiratory arrest.

"In hospital settings where cocaine is used, we have the proper breathing apparatus should a toxic reaction occur," says Michael Johns, MD, an otolaryngologist at Johns Hopkins Hospital, Baltimore, Maryland, and past chairman of the academy's committee on medical devices and drugs.

"The public does not. The public also doesn't know that if someone overdoses on cocaine in a recreational setting, cardiopulmonary resuscitation may be a lifesaving treatment."

Dr Johns adds that anesthetic agents such as lidocaine and amphetamines, which mimic the numbness that cocaine causes in the tongue, are often used to dilute cocaine, and amphetamines, caffeine, or strychnine can be added to stimulate the high the user expects from the drug.

Inhalation through the nose continues to be the most popular route of administration for recreational users of cocaine, and the chemicals and contaminants in quantities of the drug bought on the street can often damage the delicate tissues of the nose, the otolaryngology academy noted.

Dr Fairbanks said symptoms include nasal obstruction, crusting, perforation of the nasal septum, nosebleeds, and whistling with nasal breathing.

New York US crack centre

WASHINGTON — The "crack" form of cocaine is still confined mainly to the New York area in the United States, although the drug can be found in most major US cities.

A three-month study by the US Drug Enforcement Administration (DEA) has found 80% of the drug originates in New York. There are up to 30,000 dealers in the area, but they deal in small quantities — a gram to an ounce — and would not normally be DEA targets.

The agency report said while crack may be the drug of choice in New York city, most people in the US use cocaine hydrochloride, generally snorting it.

The DEA study was limited to cities in which it has resident agents. Cities with significant amounts of crack available are Detroit, Houston, Miami, and Atlanta. Crack is found to much lesser degrees in such cities as Los Angeles, Dallas, and Washington.

Although crack remains the drug of choice for only a minority of users, the enormous media attention to the drug has exaggerated its prevalence, the study said.

AIDS care relies on volunteers

By Lillian Wylie

VANCOUVER — The traditional mental health system is failing to provide continuity and coordination of care for AIDS patients.

"AIDS is not a gay disease. From the institutional and community perspective, AIDS is a medical crisis," Lynn Petrie, MSW, told the Canadian Psychiatric Association annual meeting here.

"Too much has been left to the gay community. Support for people with AIDS is seen as support for the gay lifestyle.

"AIDS is not the property and responsibility of the gay community. It is the property and responsibility of the medical and mental health care systems. It is very disturbing that our society has relied so heavily on a volunteer response to health care for those suffering from an epidemic disease," said Ms Petrie, of St Boniface Hospital, Winnipeg, Manitoba.

She took health professionals to task for allowing myth, superstition, and stigma to affect their attitudes about AIDS patients.

"As products of our society, we all have been exposed to and internalized homophobic teachings, whether we are aware of it or not. The fact that AIDS is firmly linked with sex has led some to see the disease as the fault of the victim."

Mental health professionals must confront their own damaging stereotypes of homosexual or drug-abusing patients and "our own personal apprehensions about the illness, including our own potential susceptibility to it."

GILBERT

A letter to Dr Howell

December 1, 1986

Dear Wayne,

I enjoyed our dinner the other evening. It was good to meet you after admiring your work for so many years. We didn't make as much progress as I had hoped toward writing a joint column or pair of columns — too much time was spent discussing politics. But, we said enough to establish that **The Journal**'s two long-time columnists have similar views about the drug abuse industry.

At one point, we talked about the benefits of drug use to society — perhaps a good topic to work together on.

I would raise the big questions (what is a benefit to society? how much is enough? etc), lightly gloss over current research, and conclude with a mildly provocative assertion and a plea for more work. You would provide the big answers in yet another wry exposure of contemporary follies.

We could reverse roles. I could try my hand at humor, or even satire. You could be serious and dull.

My device might be a society without drugs. It would be perfect or rotten to the core, depending on my mood.

We could reverse roles. I could try my hand at humor, or even satire

The perfect, drug-free society would be a paradise of longevity, productivity, and calm. There would be few accidents, fires, infidelities, and assaults. There might be little to write about.

The rotten, drug-free society would allow more scope for the apprentice humorist. Almost unmentionable evil could rage, unchecked by pharmacological distraction.

You, Wayne, could write loftily about the social benefits of moderate use of drugs, even of hard drugs — for example, how they stave off boredom, stimulate the economy, divert politicians, and provide opportunities for cathartic fulmination.

You could be truly academic and argue the evolutionary advantages of drug use, which may be considerable. A population with drug-users likely contains more genetic variability than one with none, and thus may be in a better position to cope with environmental change. Drug use may, on balance, also help keep numbers in check.

Your centrepiece could be an intricate and well-researched estimation of optimal levels of drug use — a fine blend of econometrics, quantitative ethics, and biostatistics. You could demonstrate the consistency of your conclusions with reports in the anthropological and historical literature of societies that declined because of too little or too much drug use.

Finally, you could suggest strategies for achieving optimal drug use, borrowing from current writings on social policy-making and systems management.

Why waste all this on a couple of columns? Why not a book? *Advantages of Drug Use* by Howell and Gilbert. It would be denounced so soundly in **The Journal** and other respectable organs, we might have a bestseller. Do you know a publisher?

Seasons greetings!
Richard

By Richard Gilbert

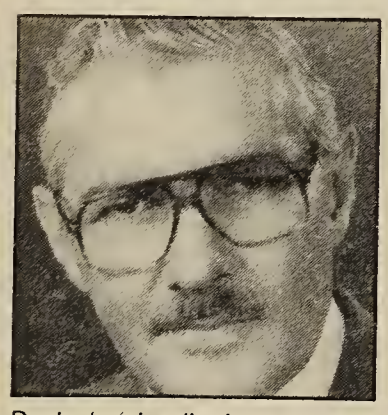
The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editonal (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Alcohol, tranqs biggest problems



Doyle: 'misleading'

Despite political attention directed at drug 'epidemic'

It is indeed heartening to see governments in the United States and Canada announce strong positions against the growing use of "hard" drugs (cocaine, crack, heroin, etc) in our society.

However, we feel it needs re-emphasizing that the drugs still causing the most problems, certainly in Canada, are alcohol and such prescription items as diazepam (eg, Valium), chlordiazepoxide (eg, Librium), and the like.

Sometimes, the use of the word drugs is misleading, but as a general rule it is meant to include alcohol, Valium, etc.

It bears pointing out that the most recent announcements by both governments apparently refer to "hard" drugs only.

Let us not lose sight of the fact that alcohol is legal, is widely available, and is accepted by our society.

If the real facts could ever be unearthed, perhaps the word "epidemic" could be used in reference to alcohol more so than to "hard" drugs.

Tom Doyle
President
Canadian Addictions Foundation
St John's, Newfoundland

Mulroney: mislabelling

More info geared to youth would help: Native leader

As a Native Indian of British Columbia, I am involved in the National Native Alcohol Drug Abuse Program, Health and Welfare Canada.

One of the target groups in my programs is Native Indian youth.

I feel there should be additional information in **The Journal** geared specifically to the younger generation, whether it be education, research, or general information on alcohol or other drugs affecting our youth.

Ben Pierre
Sechelt Indian Band
Sechelt Alcohol Alternative Program
Sechelt, British Columbia

Prisoner draws on past

A lesson worth sharing

Presently, I am incarcerated for various alcohol- and other drug-related crimes at an Ontario correctional institute. Because of my motivation to change, this treatment facility has been beneficial in helping me help myself.

Because of my prolonged drug abuse, I've had to learn and accept many things which I disliked about myself.

After a decade and a half of drug abuse, I feel very fortunate to still be able to understand that my irresponsible behaviors were my own choice. Although most of the substances I abused created psychological addiction, I convinced myself I couldn't function without drugs and successfully escaped my personality disorders.

Now, I look at the past as not a totally lost 15 years, but as an experience that will help me educate others. They need not take the route I chose.

Recently, I was on a pass, and, although I felt apprehensive about the street because I've been inside for a year, I felt no fear. I was able to cope, which is new to me.

One thing I've rediscovered about myself is that I am an intelligent and creative person. I've been encouraged to write about my past experiences so others may benefit from them.

On release, I plan to be involved with a volunteer group like Parents Against Drugs. I feel confident that because I have set some realistic goals and developed some strategies to maintain my self-esteem, my irresponsible behaviors are a thing of the past.

Zoltan Lugosi
Brampton, Ontario

Howell cheer

I continue to enjoy the informative articles in The Journal, especially those by Wayne Howell.

Brian Stowe
Ottawa, Ontario

Outcome needed in seizure case

I read with interest the report on search and seizure cases (September). In particular, I am interested in Case 2.

Would you be able to inform me if the judgment is reported, or how I can obtain a copy of the same?

Eric L. Teed
Saint John Civil Liberties and Charter Rights
Saint John, New Brunswick

(Ed note: A copy of your letter has been forwarded to Robert Solomon, University of Western Ontario, London. His students prepared the case studies.)

The Journal

Published monthly by Addiction Research Foundation (WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

33 Russell St, Toronto, Canada M5S 2S1

PULL OUT

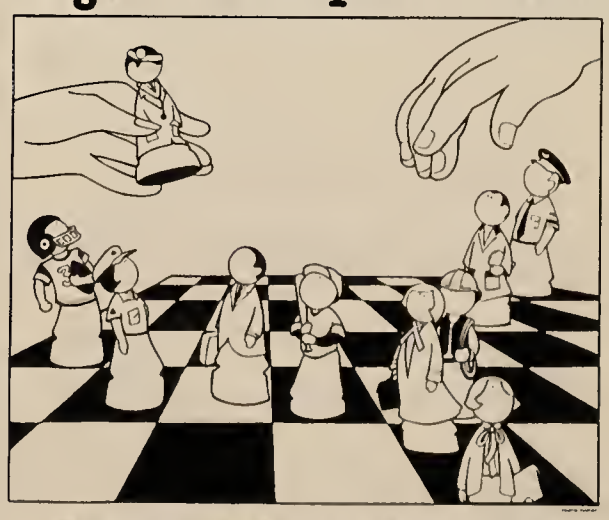
INDEX FOR 1986

January

February

March

Rights and responsibilities



The Journal
INDEX FOR 1986

April

Kids on the run — 'drugs just make it easier'

May

June

July

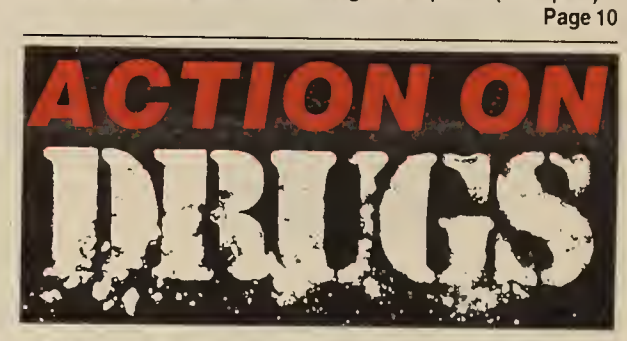
The Journal INDEX FOR 1986

Rock's role in drugs

Quiet Riot, telling you to party, not go home and read Emily Dickinson

August

September



October

The Journal

INDEX FOR 1986

November

December

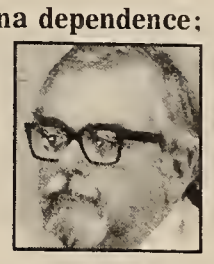
Marijuana Dependence

SAN FRANCISCO — While a conference on marijuana dependence may have produced yawns a decade ago (see page 1), the topic — and the setting, in this city which saw the origins of flower power and the drug culture back in the 1960s — drew national attention in the United States in 1986.

Delegates here heard of marijuana dependency first-hand — from a recovering marijuana abuser, as well as from the parent of a recovering addict — and from a variety of experts involved in treating drug dependents, both adults and adolescents.

The speakers discussed the neurophysiology of marijuana dependence; stages in progression, using the disease concept; specific issues in treatment; and, the effects on behavior: mental and physical impairment.

Washington Contributing Editor Harvey McConnell reports.



McConnell

A national conference, San Francisco

Forest Tennant, MD, pointed out he had seen United States servicemen addicted to cannabis in Western Europe and Southeast Asia in the late 1960s and early 1970s; it wasn't until the 1980s, however, that high potency sinsemilla (seedless) strains developed by northern California growers started to take their toll.

"I could count on my two hands the number of people between the years 1974 and 1982 who walked into my clinics and said, 'I have got a marijuana problem; I can't quit.'

"Since 1982, there has been a steady stream of people, thousands."

Dr Tennant is director of research, education, and treatment for Community Health Projects, Los Angeles, California.

Instead of producing intoxication, which disappears in a few hours, the much stronger marijuana now available means many long-term users experience several problems.

THC (tetrahydrocannabinol) levels have jumped to 10% from around 1%. But, the brain registers the increase exponentially, "and the brain sees it as a 900% difference," Dr Tennant said.

Thus, it may have taken five to 15 years before low-potency marijuana caught up with people; today, there is a much shorter time interval.

Laboratory studies show that rats and monkeys will self-administer THC intravenously. They become addicted and can be withdrawn from the drug. But, on re-exposure, they return to use voluntarily, similarly to humans who relapse.

Rats addicted to heroin and rats addicted to marijuana will both go into withdrawal when administered the narcotic antagonist naloxone (eg, Narcan).

"And, that means unequivocably," Dr Tennant added, "that marijuana has opioid activity, that opioid receptor sites in the brain are affected."

Carboxy-THC is having some effect on neurologic function

The THC from one joint, in two or three hours in the bloodstream, produces euphoria in the smoker. During that time, the THC changes into hydroxy-THC, which stays in the blood for four to six hours, and carboxy-THC, which will stay detectable in the bloodstream for up to 96 hours.

"Now, opponents of drug-testing claim that it is the carboxy-THC which can be detected four or five days after a joint and that it is inactive. That is not so. We can take somebody who has smoked a joint on a Saturday night and examine him or her on Tuesday or Wednesday and find eye abnormalities, an impaired corneal reflex system," Dr Tennant added.

"Thus, the carboxy-THC is having some effect on neurologic function even though it is not producing any euphoria. But, a lot of people don't want to hear that."

And, while cocaine and alcohol grab the headlines in relation to professional athletes, it is marijuana that ends many a career at the top. "Marijuana is the number one problem in sports today," he said.

Eye/hand coordination is the key to most professional sports in the US, and it needs only slight changes in reaction — which most people would not even recognize — for top athletes to make mistakes.

Dr Tennant said the technology is available to measure how long compounds stay in the bloodstream. Studies show there are subgroups of people who use the 'big five' illegal drugs — heroin, cocaine, marijuana, PCP, and amphetamines — and two legal drugs, alcohol and nicotine, "and who have a biological need or desire to keep that drug in the bloodstream at all times. They never let it leave."

A phenomenon he and others in the drug-abuse field have observed is the number of people addicted to only one marijuana joint a day. But, they cannot give up that one joint.

Dr Tennant: "It is obviously the carboxy-THC to which they are addicted even though it produces no euphoria."

He monitored a group of patients and found that after they gave up smoking marijuana, the carboxy-THC remained in their bloodstream for about a week. Then, when it cleared the bloodstream, the patients started to go into withdrawal.

Dr Tennant told the conference here the worst news is that severely addicted marijuana users often can't be helped.

"I've got to tell you my cure rate is small because when they come to see me, they are in deep trouble. And, there is no medical withdrawal treatment for marijuana addiction.

"We have nothing. All we can do with marijuana addicts is to counsel them. This is why prevention programs on marijuana are absolutely essential."

Studies show the brain produces natural stimulants like norepinephrine and dopamine. Drugs upset this internal clockwork: heroin will substitute for endorphin, cocaine for norepinephrine and dopamine, PCP most likely for serotonin, alcohol for GABA (gamma-aminobutyric acid), and the best research available in animal and human studies indicates marijuana primarily attacks norepinephrine and endorphins.

"Thus, as the brain looks at it, marijuana seems to be a weak cross-drug between cocaine and heroin. Weak, yes, but for the brain, it is a half stimulant and half opioid. Thus, the pulse may go up but the blood pressure down, and the eyelids may droop," Dr Tennant declared.

There's still denial marijuana does anything but make people feel good

Helen Jones began studying the possible harmful effects of marijuana in 1970 with her late husband, Hardin Jones, then professor of health sciences, at the University of California at Berkeley. They wrote two books on their findings.

She recalled for the conference the successful lobbying by pro-marijuana forces in the early 1970s which convinced the public that the drug was benign. These efforts were aided by a US national commission which reported, after a two-year study, that there was very little proven danger of physical or psychological harm from experimental or intermittent use of marijuana, and that there was no trend to more intensive use and no chance of marijuana leading to other drugs.

Ms Jones said she constantly has to update information in her books: to date, 423 identifiable substances have been found in marijuana, and 62 of them are considered potentially biologically active.

"More than 20 years have passed since the beginning of the drug epidemic, and, during this time, more than 6,000 studies have been carried out on marijuana. The bulk of the studies show marijuana use produces or has the potential to produce adverse effects on physical or mental functioning. But, there is still a denial by man that marijuana does anything more than make people feel good."

Researchers agree children and adolescents, pregnant and breast-feeding women, heart patients, and the emotionally disturbed should not use marijuana. Even healthy adults who use the drug chronically should be concerned about the long-range effects.

Preventing cocaine abuse depends on decreasing marijuana and alcohol use

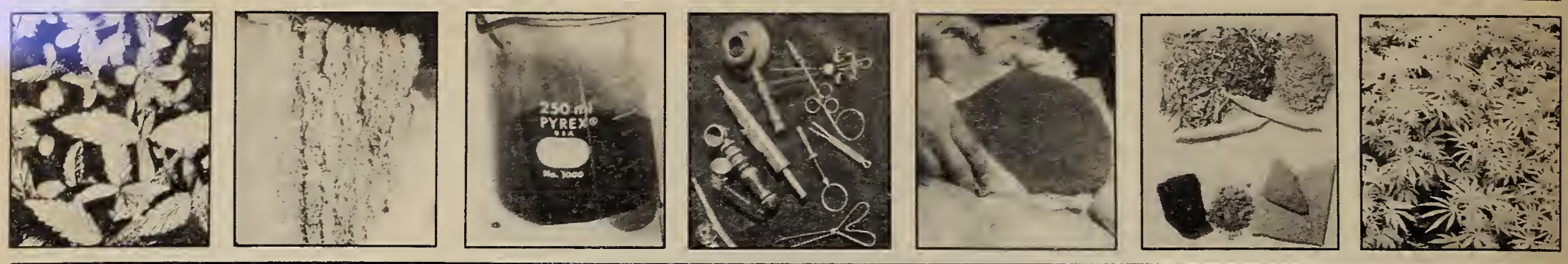
Kathleen O'Connell, PhD, a clinical psychologist in Santa Cruz, California and author of a recent book on cocaine addiction, cited the report by Mark Gold, MD, co-founder of the 800-COCAINE hotline, in the *Psychiatric Annals* in April on the cocaine-marijuana connection.

Dr Gold reported the probability of cocaine use increases with the frequency of marijuana use and the overwhelming majority of cocaine users first used marijuana. He said preventing cocaine use depends on decreasing marijuana and alcohol use among young people.

Dr O'Connell said she has treated more than 200 people, in the immediate past, who came to her with marijuana as their primary drug of abuse.

But, what is most striking is the number

(See page 8)



(from page 7)
of couples in their 30s who have used marijuana for years and who are now seeking help because they cannot conceive. "I see this (problem) with increasing frequency," said Dr O'Connell.

She speculated it'll take three generations before a dent is made in the problem: "The first generation believes there's a problem and begins to discuss it, the second generation takes steps to disseminate the information. But, it's not until the third generation that there are real changes."

She, like Dr Tennant, finds it difficult to treat marijuana addicts and believes her success rate is much lower than it is for those with cocaine addiction.

Anecdotal reports suggest amino acids may help in withdrawal from marijuana, along with aerobic exercises and withdrawing caffeine and sugar from the diet.

We no longer take kids whose parents are not willing to be involved

The pain and frustration of working with marijuana-abusing adolescents — and not getting anywhere — convinced Julia Ross she was indulging in a lost cause unless she involved their parents.

Parental involvement was the impetus for inception of the model she developed as director of adult and adolescent chemical dependency treatment at Henry Ohlhoff Outpatient Programs in the San Francisco area. The gratifying, and unexpectedly high, success rate of the first led to the opening of two more programs in the area.

Ms Ross said she, like many others before and since, had tried and failed to help adolescents in the program on their own. In addition, she had heard repeatedly of parents who had taken their children from therapist to therapist, being told drugs were not the problem and the way they were rearing their children — not giving them enough space — was. Yet, the parents knew drugs were the problem.

"One of the worst ordeals of my life was to sit week after week in a room with abusing adolescents and to realize that without parental support, they were just not going to make it."

The San Francisco program started with the explicit rule "we would no longer take any children whose parents were not willing to be thoroughly involved in the program and by that we mean three times a week, which is not easy for many parents."

So far, they have seen some 3,000 children ranging in age from 14 to 30 years — the 30 year old had been on marijuana since his early teens and still acted like an adolescent.

The San Francisco city area is the toughest because there are more parents who are also abusing drugs and who won't admit they have problems. In contrast, neighboring Costa county has mainly high-income, mainly intact families and in Marin county, there is a mix of a lot of adult drug use, plus a lot of money.

Ms Ross said so far they seem to have an overall 80% success rate in the three areas. Success is judged by the adolescents remaining abstinent for a year after leaving treatment, the parents remaining abstinent, and both the adolescents and parents continuing to follow guidelines, including regular Narcotics Anonymous or Alcoholics Anonymous attendance.

Ms Ross: "The kids are the least of our problem. The main thing is the parents, and our program is really a home recovery program. It is the parents who create the environments through which the kids can recover."

It is not difficult to get adolescents to enter treatment once they get the message their parents will go to any lengths to help them with their drug problems.

"Even the most outrageous kids I have ever seen will do what their parents tell them, and part of it is because the kids want to get better.

"We don't want any kids to fail — if they do, they will be out on the streets using again, and this time might kill themselves. We are ready to send those with the most serious problems to a residential hospital program initially," Ms Ross adds. This happens with about 20% of their clients.

However, hospital treatment is followed by the usual outpatient counselling for adolescents and parents.

Ms Ross: "Many people with hospital programs don't realize that the adolescents become heroes and go home as heroes, but to parents whose roles are unclear and who think the adolescents have been cured."

Ms Ross said they originally thought one of the trickiest parts of the program would be questioning parents about their drug use, "but, much to our amazement, if parents are willing to bring their kids in, they know their own use is going to be questioned. We have very few parents who refuse to abstain."

Siblings are not ignored and they are included in parts of the program as well.

Marijuana was found in 60% of cases testing positive, followed by cocaine, alcohol

Robert Taggart, vice-president for public affairs for the Southern Pacific Transportation Co, which has 28,000 employees in the 14 states in which it operates, said the railroad's aggressive program to find alcohol and other drug abusers has paid off both in safety and rehabilitation.

Studies have shown up to 75% of those who do drugs do them while at work. Many railroad jobs are tedious; people often sit around for long periods; and, the company operates 24 hours a day, so supervision is difficult.

The dangers are real. Mr Taggart: "Railroads carry every conceivable type of commerce, from cornflakes to vinyl chloride. We can blow up your town just like that."

Safety has always been highlighted, and, since 1897, the company has had a rule no employee can report for work under the influence of alcohol. Since 1977, this has been extended to include other drugs.

"But, the rule says no drugs or alcohol in the system, and not whether they are impaired by these drugs. This has nothing to do with free time. What you do in your free time is none of my business as your employer. So if you can go out and find a drug to use on the weekend and be clear on Monday, there is no violation of the rule."

The Southern Pacific has introduced mandatory drug testing in accidents in which 'human factors' are believed responsible.

Any initial positive test result is double-checked: two different labs carry out different tests. So far, there has been 100% correlation.

Mr Taggart said in the first two years of urine testing, 653 people out of 2,000 tested were positive for alcohol or other drugs. The results in safety terms are dramatic: in the two years before testing, there were 1,582 human factor accidents; but, there were only 481 in the two following years.

He said among those testing positive, marijuana was found in 60% of the cases, followed by cocaine, then alcohol. Those who complete rehabilitation return to work without loss of seniority.

Doctors have been woefully behind in their attitudes toward drugs

Harsh words for his fellow doctors were expressed by Erik Voth, MD, medical director for the St Francis Hospital's Chemical Dependency Unit, Topeka, Kansas, who specializes in treating marijuana abusers.

"Doctors have been woefully behind in their attitudes toward drugs, although they are finally beginning to change. But, it was only a few years ago that one could look at the American Medical Association's *Family Medical Guide* and see marijuana and cocaine classed as soft drugs with little addictive potential."

Dr Voth said those who exhibit the long-term effects are only the tip of the iceberg, and "we are dealing with a multitude of individuals who are addicted to marijuana." Marijuana belongs in the addictive disease category.

He has little time for those he thinks look at addicts in a disparaging way, for those who look at personality problems as personal weaknesses. He has found some of the people are impulsive, investing their time in the immediate environment and, in dealing with social stress, often finding it difficult to turn down drugs or alcohol.

Dr Voth thinks the disease concept is misused by some: that only the predisposed are at risk and not those who may use marijuana or cocaine on a weekend.

Those in the prevention and treatment fields are hampered by the message by some that there can be "responsible" drug use by adolescents, he says.

"There is no such thing as 'responsible' drug use when their psychosocial and psychosexual personalities are developing and preclude any ability to make responsible decisions."

He claimed that marijuana "has received more good press than any other harmful drug except perhaps alcohol."

In addition, "we have gotten off of the issue of physical effects of marijuana, and we have overlooked what is happening in terms of the addictive effects. No one in my unit comes in because they were responsible in their drug use."

Dr Voth said compared with other drugs, deteriorating interpersonal relationships and a love-trust relationship with marijuana show up very seductively and very quietly.

"Young people have been sold a bill of goods that other drugs are bad, but marijuana is not so bad."

Dr Voth demands heavy family involvement in recovery programs.

"Without the family, it is like trying to treat a diabetic without insulin."

A national conference, San Francisco

Tobacco first public health target of Royal College

TORONTO — For the first time in its 57 years, the Royal College of Physicians and Surgeons of Canada has taken a stand on a public health issue.

It wants Canada to stop growing tobacco by the year 2000, non-smokers protected from second-hand smoke, and effective help for smokers who wish to stop. It also says children should be taught not to smoke.

The College is the regulatory body for specialist training of Canadian physicians and represents 22,000 medical specialists. Last year, it formed a health and public policy committee to prepare policy statements on a number of health issues; cigarette smoking was the first.

The statement was prepared by David Sackett, MD, professor of clinical epidemiology and biostatistics at McMaster University, Hamilton, Ontario.

"Canadians now die from smoking at a rate equivalent to the crash of a jumbo passenger jet every four days," the policy statement says.

The statement also notes Canadian tobacco growers, who provide 99% of the tobacco for Canadian cigarettes, are reluctant to stop growing a crop that "brings in from three to 25 times the profit per acre as the next most profitable crop" and recommends growers receive financial assistance during the transition to other forms of agriculture.

Although the statement doesn't spell out the "effective strategies" that should be offered to smokers who want to quit, Dr Sackett told **The Journal** they include individual counselling, repeat visits and reinforcement by physicians, and nicotine gum, if incorporated with a counselling program.

To counter the $96 million annual advertising budget of the tobacco industry, the College recommends equal space and dollars be devoted to anti-smoking advertisements in every medium and at any public event that advertises cigarettes.

Alberta doctors' plea ignored

Press group vetoes cig ad ban

EDMONTON — Alberta doctors have failed to get the provincial press council to rule provincial newspapers and magazines should not carry tobacco advertising.

Last year, doctors attending the annual meeting of the Alberta Medical Association (AMA) voted to urge provincial newspapers to follow the lead of the *Kingston Whig-Standard* (**The Journal**, February, 1985) in voluntarily stopping the advertising of tobacco products.

When this move generated little response, all negative, from publishers in the province, the AMA went a step further and decided to go before the Alberta Press Council to argue that the newspapers were violating the Canadian Code of Advertising Standards by advertising a product which is not safe.

Representatives of the association appeared before the press council in September.

At the annual AMA meeting here Sandy Murray, MD, who is a member of the press council as well as a member of the AMA board of directors, relayed the bad news. The press council had not made an official response, but had ruled it did not have jurisdiction over member publications. In addition, the council decided the press was already doing a good job in informing the public about the hazards of cigarettes.

Clean air in waiting rooms a must, anti-smoking physician insists

EDMONTON — Alberta doctors have been strongly lectured by one of their own on their attitudes toward smoking.

The attack came from Alex McPherson, MD, Alberta's provincial deputy minister of hospitals and medical care. He says he knows many doctors who don't ban smoking from their own waiting rooms.

Dr McPherson: "I have attended physicians' offices where there has been so much smoking going on that some of the other individuals in the waiting rooms were actually having asthmatic attacks."

He told an Alberta Medical Association meeting here that he has also seen doctors appear on television smoking.

New Books

by MARGY CHAN

Issues in Identifying and Treating Substance Abusers among Hospitalized Patients

. . . prepared by Edward Sawka

The first title in the new Alberta Alcohol and Drug Abuse Commission monograph series, this paper focuses on patients with alcohol or other substance abuse problems, hospitalized for a variety of reasons, whose underlying primary addictive disorder escapes diagnosis and treatment.

It is written concisely and uses a well laid-out format. Medical and health professionals, hospital administrators, and policy makers will find this paper useful and informative.

Alberta Alcohol and Drug Abuse Commission, Edmonton, Alberta, Canada. 1986. 43 p. $6.

Our Daily Fix: Drugs in Australia

. . . by Valerie A. Brown, Desmond Manderson, Margaret O'Callaghan, Robyn Thompson

This book discusses drug use and abuse in Australia today: the social context of drug use, drug policy, politics, and values. It examines different strategies employed at government and community levels to reduce drug abuse and outlines plans for action.

The book contains a list of drug abuse prevention programs, projects, resources, and services available in Australia.

The notes for further reading and an extensive bibliography will guide the serious reader to further research.

Australian National University Press, Pergamon Press, Rushcutters Bay, New South Wales, Australia, 1986. 304 p. ISBN 0-08-033044-4.

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Profile of a Drug User

Number: 755.
Subject heading: Drug use: etiology and epidemiology.
Details: Four, 10-min filmstrips with audio cassettes.
Synopsis: There are many different kinds of people who, for various reasons, use drugs to achieve an altered state of mind. Teenagers are especially susceptible to the effects of drugs: adolescent years can be difficult, teens are learning new behaviors and how to deal with conflicts. Three young people discuss their anxieties about school, home, and summer employment. Drugs are shown as the way two of these young people deal with their stress.
General evaluation: Fair to good (3.7). The filmstrips discuss drug use in terms of coping with stress and neglect consideration of other influences, eg, family background.
Recommended use: With a resource person, the filmstrips could be used with young people between 12 and 18 years.

Drugs and the Older Individual

Number: 760.
Subject heading: Senior citizens.
Details: 15 min.
Synopsis: A woman finds bottles of pills in the medicine cabinet her husband has kept long after expiry date. Concerned about what he should really be taking, they visit the doctor. Seniors must be particularly careful about using drugs since drugs are distributed more slowly through their bodies and are not metabolized as quickly as in younger people. It is important that people take an active role in their own health care.
General evaluation: Good to very good (4.8). This video has good information, clearly presented. The graphics enhance the messages, and the modelling of good health behavior makes this a good teaching aid. General broadcast is recommended.
Recommended use: The video could benefit seniors and their families.

No One Says Hello Anymore

Number: 748.
Subject heading: Alcohol/alcoholism overview.
Time: 45 min.
Synopsis: Sal Vella introduces the story of Paul, an alcoholic. The character he plays is a composite of many alcoholics. Paul is shown having difficulty getting up in the morning and being confronted by his son for forgetting a hockey game. Paul's wife is angry with him for his drinking; his son recalls having to call the police when Paul beat his wife while drunk. Later, Paul's boss confronts him about his poor work performance and orders him to get treatment for his drinking. In anger, Paul quits, confident of getting another job. However, he is rejected because of his reputation. That evening, a woman picks him up; they go to a hotel room where he passes out. He gets home after having been arrested for drunk driving. His wife gives him an ultimatum: get help or get out. Paul goes for treatment and eventually finds recovery is wonderful.
General evaluation: Very poor to poor (1.7). The film loses potential impact because it is melodramatic and exaggerates stereotypes.
Recommended use: Although some people in treatment might empathize with the character in this video, the length and poor quality detract from its usefulness.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Management for Supervisors in the Health Care Setting — Dec 8-9, Halifax, Nova Scotia; Dec 10-11, Jan 16-17, 1987, Toronto, Ontario; Jan 12-13, Vancouver, British Columbia; Jan 14-15, Calgary, Alberta. Information: Conference and seminar services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

Fundamental Concepts Course — Jan 12-16, 1987, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Drinking and Drugs: Use and Abuse, A Multi-Media Distance Education Course — Begins Feb 2, 1987, Canada. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Addictions Foundation Atlantic Conference 87 — April 26-30, 1987, Saint John, New Brunswick. Information: Roger A. Alain, information officer, Alcoholism and Drug Dependency Commission of New Brunswick, PO Box 6000, Fredericton, NB, E3B 5H1.

PRIDE Canada 3rd National Conference on Youth and Drugs —May 14-16, 1987, Saskatoon, Saskatchewan. Information: Eloise Opheim, president, PRIDE Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

United States

SECAD XI: Southeastern Conference on Alcohol and Drug Abuse — Dec 3-7, Atlanta, Georgia. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, 11050 Crabapple Rd, Ste D-120, Roswell, GA 30075.

13th Annual Advanced International Winter Symposium: — Feb 1-6, 1987, Colorado Springs, Colorado. Information: Jeffrey D. Elliott, symposium coordinator, Psychotherapy Associates, 3208 N Academy Blvd, St 160, Colorado Springs CO 80907.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, 1987, Orlando, Florida. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, FL 33069.

10th Annual Alcohol Symposium, Diagnosis and Treatment: New Perspectives on Old Dilemmas — March 7, 1987, Boston, Massachusetts. Information: Judy Reiner Platt, Cambridge Hospital, 1493 Cambridge St, Cambridge, MA 02139.

PRIDE 1987 International Conference on Drugs — March 19-21, 1987, Atlanta, Georgia. Information: Jean Alford, National Parents' Resource Institute for Drug Education, Inc, 100 Edgewood Dr, Ste 1216, Atlanta, GA.

5th National Symposium on the Impaired Nurse— March 25-27, 1987, Atlanta, Georgia. Information: National Nurses Society on Addictions, 2506 Gross Point Rd, Evanston, Illinois 60201.

American Society for Clinical Pharmacology and Therapeutics Annual Meeting — March 25-28, 1987, Orlando, Florida. Information: Elaine Galasso, executive secretary, 1718 Gallagher Rd, Norristown, Pennsylvania 19401.

American Orthopsychiatric Association Annual Meeting — March 25-29, 1987, Washington, DC. Information: Marion Langer, executive director, 19 W 44th St, Ste 1616, New York, NY 10036.

National Alcoholism Forum and Medical Scientific Conference on Alcoholism — April 22-27, 1987, Cleveland, Ohio. Information: Forum coordinator, National Council on Alcoholism, 12 W 21st St, New York, NY 10010.

Abroad

6th Annual Conference of the Australian Medical Society on Alcohol and Drug Related Problems — Dec 9-12, Perth, Western Australia. Information: Kari McLaughlin, Western Australian Alcohol and Drug Authority, Construction House, 35 Havelock St, West Perth, 6005 Western Australia.

International Federation of Non-Governmental Organizations for the Prevention of Drug and Substance Abuse 8th Annual Conference —Dec 13-19, Sydney, Australia. Information: Chairman, program committee, PO Box 477, Canberra City ACT 2601, Australia.

Symposium on the Prevention of Alcohol Misuse Among Children and Young People — Feb 25-26, 1987, London, England. Information: Institute of Alcohol Studies, Alliance House, 12 Claxton St, London, SW1H 0QS.

The International Congress for Alcoholism and Drug Abuse Counselors — March 13-21, 1987, London, England. Information: Tom Claunch, PO Box 210638, Montgomery, Alabama 36121.

7th International Conference on Alcohol Problems — April 5-10, 1987, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $15.21 per column inch minimum 1", sold in ¼" increases
d) Positions Available, $14.26 per column inch, minimum 1

Circulation: 23,381 (Canada, 19,761; USA, 1,097; Foreign, 314, Bulk, 3,620) Media 2,149

Single Subscription Rates:
Ontano Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year
Microfiche: $24 per year
Air Mail; add $19 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

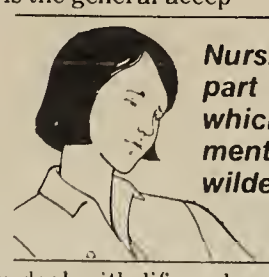
The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

Addictions in nursing: reality versus image

By Elda Hauschildt

TORONTO — Conflict between romanticized images nurses have of soothing the sick, Florence Nightingale-style, and the reality of patient care in today's technical hospital setting is one cause of alcohol and other drug problems within the profession.

And, another cause is the general acceptance in North American society that there must be a cure — a drug — for every ill and stress, physical or emotional.



Nursing is a small part of patient care, which is now fragmented beyond our wildest dreams

It is "too simplistic," however, to blame nurses' addictions on the fact they deal with life-and-death situations and have access to drugs on the ward, says Janet Gaskin, founder of Project Turnabout, an Ontario treatment program for addicted nurses, and director of nursing at the Addiction Research Foundation (ARF) here.

"The addiction of nurses (**The Journal**, February, 1982) is a multi-dimensional problem, and that is a difficult message to get across to people," says Ms Gaskin.

"Television programs and magazine articles on the subject focus on job skills and accessibility, as if these were proven facts. They are not, and they are not the problems we talk about in our therapy groups.

"They may be contributing factors, a small part of the mosaic, but they are not more than that."

Project Turnabout, supported by the College of Nurses of Ontario, the Ontario Nurses' Association, the Registered Nurses' Association of Ontario, and the Ontario Association of Registered Nursing Assistants, has seen approximately 50 addicted nurses each year for the past three years.

The compelling image of "the lady with the lamp, walking through a tent of wounded soldiers, laying a hand on a fevered brow, smiling here and there, is the image nurses are imbued with," Ms Gaskin told **The Journal**.

"In 1986, there are a lot of problems with that image. The modern, North American hospital system doesn't allow that kind of conduct in the course of our work. Instead, we have computers and computerized charting. We have a high level of technology; we have a plethora of health care personnel.

"Nursing is likely to be a small part of patient care, which is now fragmented beyond our wildest dreams. There are workers who deal with every part of the patient's body and every social function: physiotherapists, nutritional therapists, play therapists; the list goes on and on.

"And, statistics show the average stay in hospital is being shortened every year. If the patient is only in hospital three to five days and you have all these other care givers, how much time do the nurse and patient get? If this is where the nurse is looking for gratification, how much job satisfaction does she get? I would guess not much."

Ms Gaskin suggests society's "cultural orientation" toward using drugs for every physical or emotional problem is an underlying factor for nurses' addictions, just as it is a factor for addictions among the public generally.

"Look at drugstore shelves; there are non-prescription, over-the-counter remedies for everything — headaches, menstrual cramps, allergies, inability to sleep — you name it.

"Our culture believes in drugs as a solution. People who go to their family doctor and don't come out with a prescription feel kind of cheated. This attitude affects everyone, not just nurses or other hospital workers. We tend to want the fast solution we can swallow."

No Canadian data are available on nurses' addictions simply because treatment programs for nurses are a recent development. Ms Gaskin points out when Project Turnabout was established in the winter of 1983, there was no Canadian model to follow.

There are workers who deal with every part of the patient's body and every social function: physiotherapists, nutritional therapists, play therapists, the list goes on and on

"Now, there are case reports and testimonials, but there is nothing you could call hard data."

The Ontario program — nurses are treated through the ARF Clinical Institute here — is tracking its clients, on a six-month basis, for 18 months. The sample is "largely alcoholic, largely employed, and largely self-referred."

Ms Gaskin: "But, of course the majority any one program sees in terms of patient number and drugs of use depends on the program's structure.

"In Florida, for example, the average patient would be a narcotic abuser, referred by an employer or someone at work. That's what the program there is set up for, to catch the lawbreaker and reinforce the licensing body's power over the registrant who breaks the law.

"The Florida program is mandatory, a diversion program. Someone who otherwise would have their licence removed, or perhaps would be prosecuted under criminal law, is diverted into a help program."

Project Turnabout, she says, is voluntary and handles mostly alcoholics because "you're more likely to self-refer if you only have to admit to an alcohol problem.

"So, I'm not sure our picture is representative of the problem at large. It's probably more representative of the fact it's much more risky for a nurse to phone up and say she has a drug problem. And — if you can envisage a continuum — it's even more risky for a nurse to have to say she has a narcotic problem and is stealing the drugs at work."

Project Turnabout's caseload of 50 clients per year represents the number of Ontario nurses seeking treatment through the project, rather than the total the program can handle. Nurses hear of it through periodicals put out by the four nursing associations, by word of mouth, or through a brochure circulated to hospital personnel and employee health departments.

Confidentiality is basic. Once contact is made and assessment is completed, an individual treatment program begins.

Ms Gaskin: "We discuss the various treatment options with the nurses, find out their personal situations, and individualize the choices according to all kinds of personal variables: where they live, where they work, whether anybody knows, whether they have children to think about. It could be one-to-one counselling over a long period of time, on an outpatient basis; it could be a three-week inpatient program. It could be involvement in our weekly therapy group, or a combination of modalities."

Project Turnabout is in transition; it has been run on a pilot-project basis, and now the nursing associations are preparing to take over its management. A governing board has been established, bylaws have been drawn up, and an in-house coordinator is being hired.

"The goal was always to convince the associations this was a valuable undertaking and to have them fund a program that would be operated by the nurses of Ontario, for the nurses of Ontario," says Ms Gaskin.

While the project changes hands, addicted nurses will continue to be treated through ARF's Clinical Institute.

THE BACK PAGE

Ms Gaskin emphasizes two areas in which work with addicted nurses needs to be developed: recognition by nurses themselves that addicted peers want to be helped, not protected, and involvement in the treatment process by managers and employers.

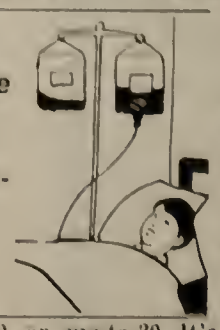
"There is a conspiracy to cover up for the addicted nurse. Her peers do protect her. They know she is in trouble — usually the rest of the person's life is in chaos — and they try to protect her and shelter her. They don't want her to lose her job or her licence to practice and they think this is likely to happen.

"The irony of the situation is that time and time again, I also hear clients say, 'I'm so relieved it's all over. Now, I can stop the charade and start to behave as someone who needs help, not as someone who has to be perfect.' "

Managers of addicted nurses also hold back, thinking they must be able to prove a nurse is addicted to alcohol or other drugs.

Ms Gaskin: "We get call after call saying, 'I can't prove anything, but . . . .' I always tell them to go back to performance management. The manager or employer needs to deal with performance, not prove the person has a drug problem.

"If managers believe they have to catch nurses red-handed, or drunk, they just walk around with their heads in the sand, hoping nothing happens. I tell them to deal with sick time, lateness, sloppy charting, and poor patient care."



If this is where the nurse looks for gratification, how much job satisfaction can she get?

Identification is complicated further because managers are "kept in the dark" by colleagues trying to protect the addicted nurse.

"The manager-to-nurse ratio is one-to-20, or one-to-30. It's very difficult also to supervise nurses because of shifts and the seven day week.

"The only way around it is to instill in colleagues the notion that you're not doing anyone a favor, not to mention putting yourself in jeopardy."